

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. ATIME(S)
SM 9/55

| MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 | | | | | | | | | | Reg. Dist. No. 08729 | | | | |
|---|--|--|---|--|---|--|-----------------------------------|--|-------------------------------------|---|--|----------------------------------|-------------------------------------|--------------------------|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto. | | | | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hampstead Rural | | | | | c. LENGTH OF STAY IN 1b 15 Years | | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hampstead Rural | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Brick Store Road | | | | | d. STREET ADDRESS Brick Store Road | | | | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print) Robert | | First N. | Middle . | Last Allen | 4. DATE OF DEATH Aug. 10 1959 | Month Aug. | Day 10 | Year 1959 | | | | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH Oct. 11, 1913 | 9. AGE (In years last birthday) 45 yrs. | 10. IF UNDER 1 YEAR Months 0 | 11. IF UNDER 24 HRS. Days 0 | 12. IF UNDER 24 HRS. Hours 0 | 13. FATHER'S NAME Merryman Allen | 14. MOTHER'S MAIDEN NAME Unknown | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | 16. SOCIAL SECURITY NO. WW II | 17. INFORMANT Mrs. Frances Allen | Address Hampstead Md. |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 976x Gunshot wound thru abdomen (suicide) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Mental Depression DUE TO (c) | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 10 min. | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Gunshot wound thru abdomen | | | | | | | | | | | | |
| 20c. TIME OF INJURY Hour a. m. 2pm p. m. 8/10/59 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home | | 20f. (City or town) Hampstead | | (County) Balto. | | (State) Md. | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) D. D. Caples | | M.D. | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED 8-11-59 | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 8/13/59 | | 22c. NAME OF CEMETERY OR CREMATORIAL Grave Run Cemetery | | 22d. LOCATION (City, town, or county) Baltimore Co. | | (State) Md. | | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Edward C. Tipton | | ADDRESS Hampstead, Md. | | 24a. REC'D BY REGISTRAR DATE AUG 13 '59 | | 24b. REGISTRAR'S SIGNATURE Carter & Kline | | | | | | | | |

A 1
FOR STATE
HEALTH DEPT.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 should be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 18 Film 249 10-7- MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

| 8770 MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | 05730 | | | |
|--|--|------------------------|--|---|--|---|--|---|--|--|-----------------|---------------------------|--------------|--------------------------------|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) | | | | | | | | | | | |
| a. COUNTY Baltimore MARYLAND | | | | a. STATE Maryland b. COUNTY Baltimore | | | | | | | | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Life | | | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fullerton | | | | | | | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 5 Leslie Avenue | | | | d. STREET ADDRESS 5 Leslie Avenue | | | | | | | | | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) MARY | | | | First | | Middle | | Last | | 4. DATE OF DEATH AMOS | Month August | Day 28 | Year 1959 | | |
| 5. SEX Female | | | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH 9/5/25 | | 9. AGE (in years last birthday) 33 yrs. | | IF UNDER 1 YEAR Months | | IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY Domestic | | 11. BIRTHPLACE (State or foreign country) Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME William Dorsey | | | | 14. MOTHER'S MAIDEN NAME Nellie Hench | | | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or date of service) No | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT 214-20-7702, Richard Amos | | Address 5 Leslie Ave., Baltimore | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | INTERVAL BETWEEN ONSET AND DEATH — | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 422.2 | | | | Idiopathic myocarditis | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) | | | | DUE TO | | | | | | | | | | | |
| DUE TO (c) | | | | | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | | | | | | | | |
| 20c. TIME OF INJURY Hour a.m. p.m. | | Month, Day, Year 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>W. Bradley King Jr.</i> | | | | | | | | | | | | | | | |
| EXAMINER'S NAME (Type) | | | | | | | | | | | | | | | |
| 22e. BURIAL, CREMATION, REMOVAL (Specify) Burial Aug. 31, 1959 Dulaney Valley Cemetery Baltimore Co. Md. | | | | | | | | | | | | | | | |
| 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORIUM 22d. LOCATION (City, town, or county) (State) | | | | | | | | | | | | | | | |
| 23. FUNERAL DIRECTOR ADDRESS Wm. Cook, Towson Inc. 1050 York Rd. | | | | | | | | | | | | | | | |
| 24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE DATE SEP 2 '59 Charles S. Kraus | | | | | | | | | | | | | | | |

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100-101

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8771 CERTIFICATE OF DEATH

08731
Reg. Dist. No. 32

| | | | | | |
|--|--|---|---|--|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson | | c. LENGTH OF STAY IN 1b | | b. COUNTY | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE CITY | | f. STREET ADDRESS 21 NORTH CARROLLTON AVE | |
| 3. NAME OF DECEASED (Type or print) NANNIE HELEN | | First | Middle | Last | 4. DATE OF DEATH ARTHUR |
| 5. SEX FEMALE | | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | B. DATE OF BIRTH AUGUST 28 1925 | 8. AGE (In years (last birthday) 33 yrs. |
| 9. IF UNDER 1 YEAR Months 0 | | 10. IF UNDER 24 HRS. Days 0 | | 11. IF UNDER 24 HRS. Hours 0 | |
| 12. IF UNDER 24 HRS. Min. 0 | | 13. CITIZEN OF WHAT COUNTRY? USA | | 14. MOTHER'S MAIDEN NAME NANCY HODGES | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO | | 16. SOCIAL SECURITY NO. 225-22-3167 | | 17. INFORMANT Address Hospital records, Mt. Wilson State Hospital | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY TUBERCULOSIS DUE TO INTERVAL BETWEEN ONSET AND DEATH 12 YEARS | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Hour p. m. 19 | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from APRIL 7, 1955, to AUGUST 24, 1959 , that I last saw the deceased alive on AUGUST 24, 1959 , and that death occurred at 2-A, M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) William Newcomer M.D. Mt. Wilson, Maryland ACTUAL SIGNATURE DATE SIGNED | | | | | |
| PHYSICIAN'S NAME (Type) William Newcomer, M.D. Superintendent | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 22b. DATE THEREOF Aug. 25/59 | 22c. NAME OF CEMETERY OR CREMATORIUM | 22d. LOCATION (City, town, or county) Rocky Mount, Va. (State) | |
| 23a. FUNERAL DIRECTOR'S SIGNATURE Witzke Funeral Directors | | ADDRESS 4101 E. Ave. | 24a. REC'D BY REGISTRAR DATE AUG 26 '59 | 24b. REGISTRAR'S SIGNATURE Arthur S. Thomas | |

OF ECONOMICS--HARVARD DIVISION OF STATISTICS

NUCLEAR ENERGY

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08732
8755 CERTIFICATE OF DEATH

Reg. Dist. No. _____

| | | | |
|--|--------------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY Dundalk Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Turner Station | | c. LENGTH OF STAY IN 1b 53 Turner Station | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 148 Carver Road | | d. STREET ADDRESS 148 Carver Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | First Mittie | Middle | Last Bailey 4. DATE OF DEATH August 1, 1959 |
| 5. SEX Female | 6. COLOR OR RACE Colored | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> Aug. 8, 1880 | 9. AGE (In years lost birthday) 78 yrs. IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Isles of White Co., Va. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME William Davis | | 14. MOTHER'S MAIDEN NAME Roberta Branch | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or Unknown) | 16. SOCIAL SECURITY NO. No | 17. INFORMANT Sallie Overby - 148 Carver Road | Address |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 480X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) influenza | | INTERVAL BETWEEN ONSET AND DEATH 5 days 1wk | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) Baltimore (County) Maryland (State) Maryland | |
| 21. I certify that I attended the deceased from July 21-59 to August 1, 1959 , that I last saw the deceased alive on August 1-59 , and that death occurred at 2 A.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE J.H. Thomas | | ADDRESS (Street, city or town, state) 12777 Main St., Baltimore, Maryland DATE SIGNED | |
| PHYSICIAN'S NAME (Type) J.H. Thomas MD | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 8-4-59 | |
| 22c. NAME OF CEMETERY OR CREMATORIAL Mt. Calvary Cemetery | | 22d. LOCATION (City, town, or county) Baltimore, Maryland (State) Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Charles R. Law | | ADDRESS 802 Madison Avenue | |
| 24a. REC'D BY REGISTRAR DATE AUG 5 '59 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Thomas | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08733

8772

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | | |
|---|--|--|--|--|---|---|-------------------------|-------|
| 1. PLACE OF DEATH a. COUNTY Baltimore | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland | | b. COUNTY Harford | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson | | c. LENGTH OF STAY IN 1b 1 yr | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air | | d. STREET ADDRESS 1232 1/2 | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Holly Hill's Manor-531 Stevenson Lane | | | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print) Robert Sterling Barnes | | First | Middle | Last | 4. DATE OF DEATH Aug. 8, 1959 | Month | Day | Year |
| 5. SEX Male | | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | B. DATE OF BIRTH Oct. 26, 1869 | 9. AGE (In years lost birthday) 89 yrs. | IF UNDER 1 YEAR Months | IF UNDER 24 HRS Days | Hours |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minister-retired | | 10b. KIND OF BUSINESS OR INDUSTRY Methodist Church | | 11. BIRTHPLACE (State or foreign country) Ashland, Va. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME Eden Barnes | | 14. MOTHER'S MAIDEN NAME Catherine Louise Baird | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. --- | | INFORMANT Mrs. Benjamin Amos, Bel Air, Md. | | Address | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute coronary occlusion DUE TO 420.0 INTERVAL BETWEEN ONSET AND DEATH 1 day Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) arteriosclerotic heart disease DUE TO 5 yrs (c) _____ | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) Abingdon (County) Md. (State) | | |
| 21. I certify that I attended the deceased from July 10, 1959 to Aug 8, 1959 , that I last saw the deceased alive on Aug 2 - 59 , and that death occurred at 9 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4808 Harford Rd DATE SIGNED 8/8/59 | | | | | | | | |
| ACTUAL SIGNATURE George Sawyer M.D. | | 22. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 8/11/1959 22c. NAME OF CEMETERY OR CREMATORIAL Cokesbury 22d. LOCATION (City, town, or county) Abingdon (State) Md. | | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Burt | | ADDRESS Jarrettville Md. | | 24a. REC'D BY REGISTRAR AUG 13 '59 | | 24b. REGISTRAR'S SIGNATURE Albert J. Krause | | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8773

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

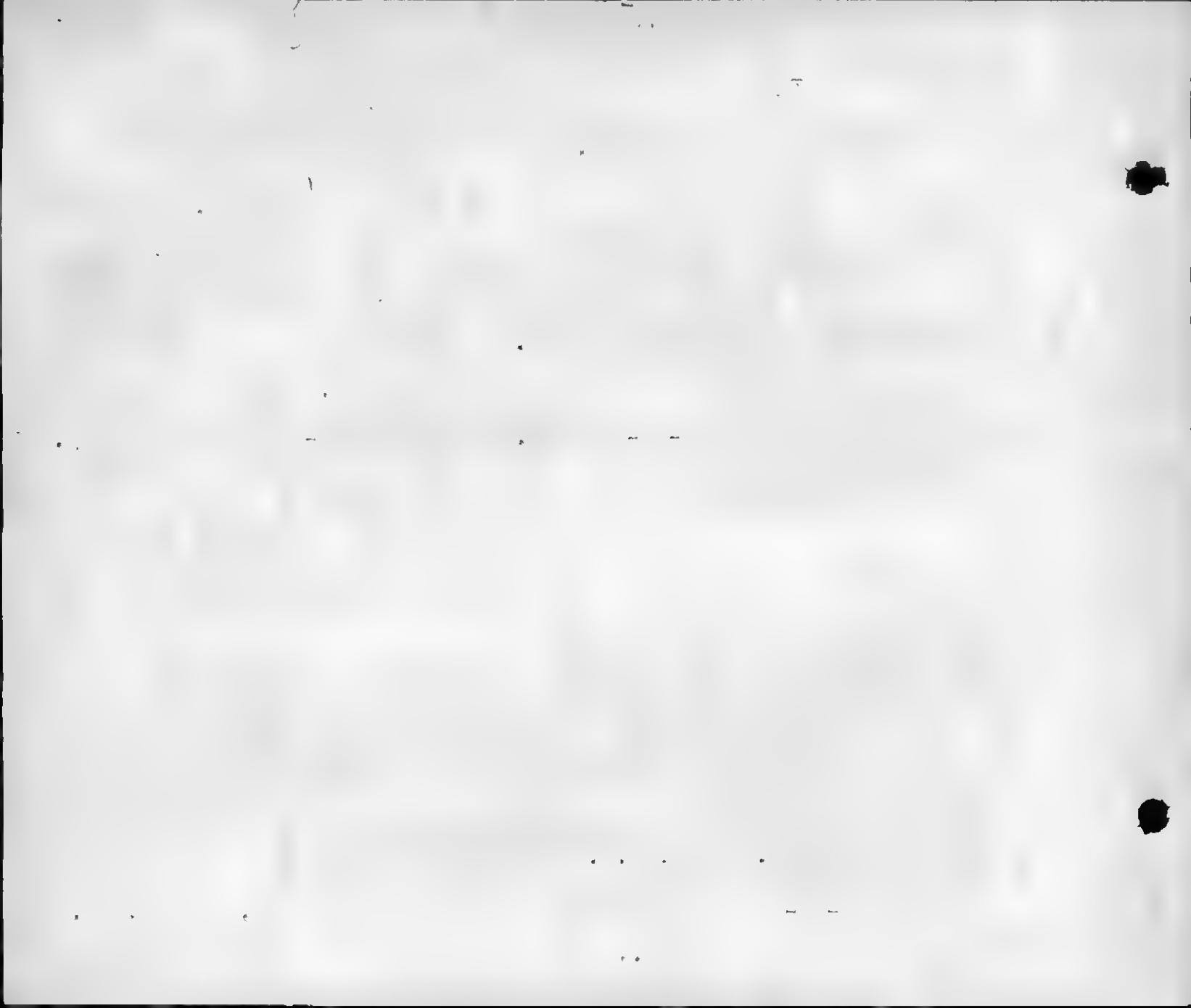
08734

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

| | | | | | |
|---|--|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY | | Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. LENGTH OF STAY IN lb 4 yrs. | | d. STATE Maryland b. COUNTY Baltimore | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | Edgemere | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | |
| 2326 Sparrows Point Road | | Edgemere | | d. STREET ADDRESS | |
| 3. NAME OF DECEASED (Type or print) | | First WILLIAM | Middle JOSEPH | Last BARNES | 4. DATE OF DEATH August 7, 1959 |
| 5. SEX Male | | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | B. DATE OF BIRTH December 22, 1893 | 9. AGE (In years last birthday) 69 years 6 months 7 days |
| 10a. USUAL OCCUPATION (Give kind of work done during working life. If retired, give kind of work done when retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Bookbinder | | Printing Indust. | | Maryland | |
| 13. FATHER'S NAME Joseph Barnes | | 14. MOTHER'S MAIDEN NAME Mary C. Quirk | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown) | | 16. SOCIAL SECURITY NO. 212-03-0132 | | 17. INFORMANT Mr. Norman Barnes-3442 Liberty Pkwy. 22 Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) | | 400.1 Coronary Occlusion | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | DUE TO (b) A-S-C-V DISEASE | | | |
| DUE TO (c) | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) No | | | |
| 20c. TIME OF INJURY Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) Melvin B. Davis, M.D. | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED 8/10/59 | |
| 22a. BURIAL, CREMATION, REBURY (Specify) Burial | | 22b. DATE THEREOF 8-11-59 | | 22c. NAME OF CEMETERY OR CREMATORIAL Baltimore National | |
| 22d. LOCATION (City, town, or county) Baltimore, County, Md. | | | | (Sign) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Walter Brooks Bradley Inc., Dundalk | | ADDRESS | | 24a. REC'D BY REGISTRAR DATE AUG 11 '59 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kline | |



TO HOSPITAL OR CLINIC: The law requires that the death certificate be executed within 24 hours of death. Page 4 -

may be retained by the hospital or attending physician and completely filled in by the funeral director.

1. UNDERTAKING
2. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

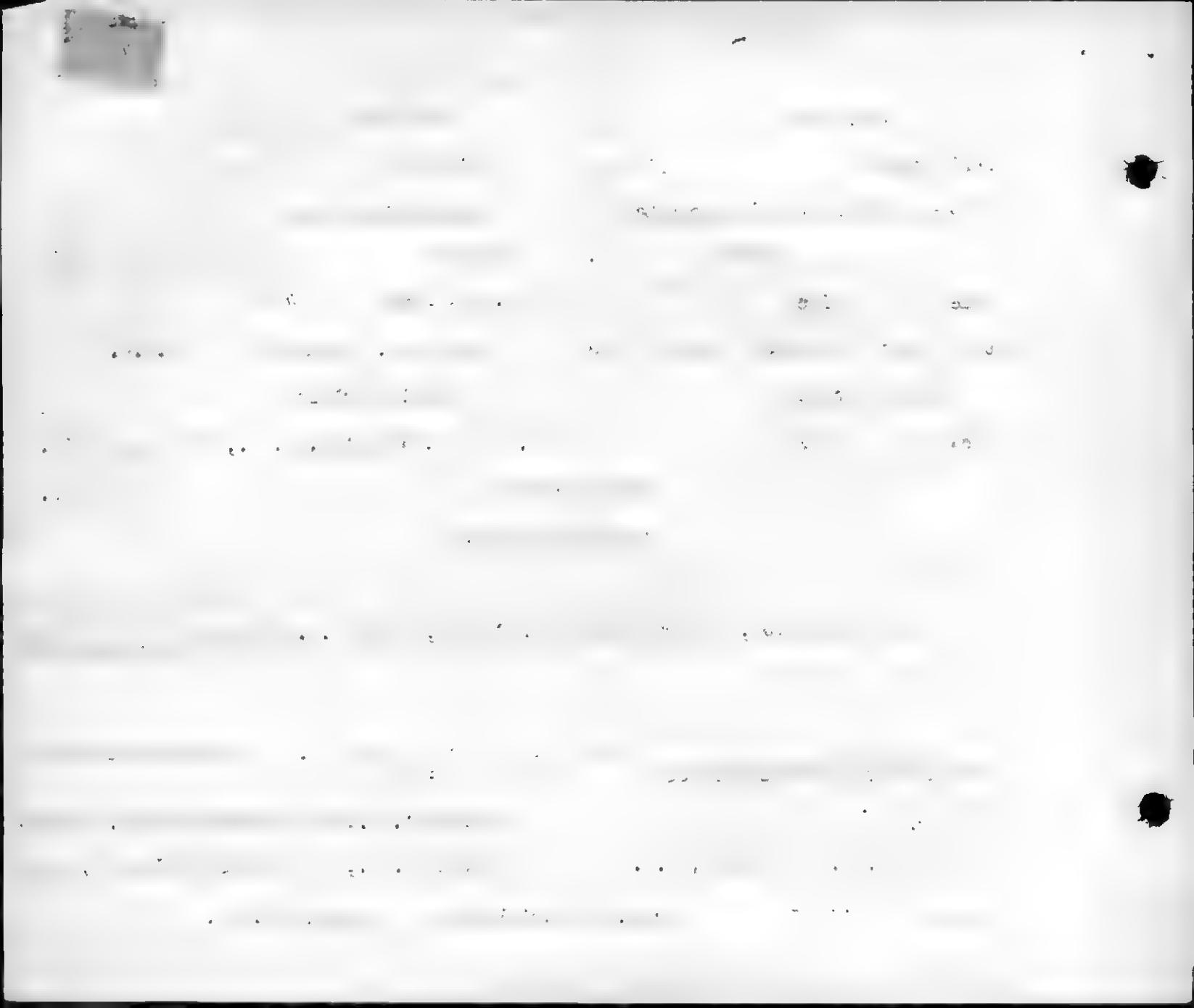
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8774

CERTIFICATE OF DEATH

Reg. Dist. No. **8735**

| | | | |
|---|-------------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard | | c. LENGTH OF STAY IN 1b 17 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) CHARLES H. BASEHART | | First CHARLES | Middle H. |
| Last BASEHART | | 4. DATE DEATH August 21, 1959 | Month Year Day Year |
| S. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Oct. 31, 1887 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Store Owner & Salesman | | 10b. KIND OF BUSINESS OR INDUSTRY Malt & Hops | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland |
| 13. FATHER'S NAME Henry Basehart | | 14. MOTHER'S MAIDEN NAME Mattie Vosburg | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO WW I | 17. INSTITUTION Clin. Records, V.A.H., Balto. 18, Md., Fort Howard Div. |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4657</i> | | INTERVAL BETWEEN ONSET AND DEATH 15-20 min. | |
| DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) | | DUE TO PULMONARY EMBOLISM | |
| DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETES MELLITUS, CEREBRO-VASCULAR ACCIDENT, UPPER G.I. BLEEDING | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) (SOURCE UNDETERMINED) | |
| 20c. TIME OF INJURY Hour o. m. p. m. | Month 19 | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |
| 20f. (City or town) VAH, BALTO. MD., FORT HOWARD DIVISION | (County) 8/24/59 | (State) MD. | |
| 21. I certify that I attended the deceased from August 7, 1959 to August 24, 1959 and that death occurred at 2:00 P.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>W. J. Pijanowski</i> | | ADDRESS (Street, city or town, state) VAH, BALTO. MD., FORT HOWARD DIVISION | |
| PHYSICIAN'S NAME (Type) W. J. PIJANOWSKI, M.D. | | DATE SIGNED 8/24/59 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 8-28-59 | 22c. NAME OF CEMETERY OR CREMATORIAL Moreland Memorial Park | 22d. LOCATION (City, town, or county) Pacilville, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE LEONARD RUCK & SONS, 5305 Harford Rd Balto Md | | 24a. REC'D BY REGISTRAR DATE AUG 27 '59 | |
| | | 24b. REGISTRAR'S SIGNATURE Arthur & Anna | |



1
TO HOSPITAL OR ENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8775

CERTIFICATE OF DEATH

08736

Reg. Dist. No.

| | | | |
|--|-----------------------|---|-----------------------------------|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town Woodlawn Life | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2031 Russell Ave. | | d. STREET ADDRESS 2031 Russell Ave. | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) | First Nettie | Middle M. Bell | Last |
| 4. DATE OF DEATH | Month August | Day 1 | Year 1959 |
| 5. SEX F | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Nov. 15, 1873 |
| 9. AGE (In years last birthday) 85 yrs | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | |
| 11. BIRTHPLACE (State or foreign country) Baltimore County | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Milton Reed | | 14. MOTHER'S MAIDEN NAME Susanna White | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. NO | |
| 17. INFORMANT Lula B. Mills 2031 Russell Ave. 7 | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]. PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Congestive heart failure</i> 122.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO <i>Degenerative heart disease</i> (c) | | | |
| INTERVAL BETWEEN ONSET AND DEATH 7 days | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>7/31. 1959</i> to <i>8/1. 1959</i> , that I last saw the deceased alive on <i>7/31. 1959</i> , and that death occurred at <i>10:00 P.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE <i>Edwin L. Pierpont, M.D.</i> ADDRESS <i>8204 LIBERTY RD</i> DATE SIGNED <i>8/3/59</i> PHYSICIAN'S NAME (Type) <i>EDWIN L. PIERPONT, M.D.</i> BALTO. 7, MD. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Aug. 4, 1959 | |
| 22c. NAME OF CEMETERY OR CREMATORIUM Woodlawn | | 22d. LOCATION (City, town, or county) (State) Woodlawn Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE John T. Stansbury 6411 Windsor Mill Rd. | | 24a. REC'D BY REGISTRAR DATE AUG 5 '59 | |
| | | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i> | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

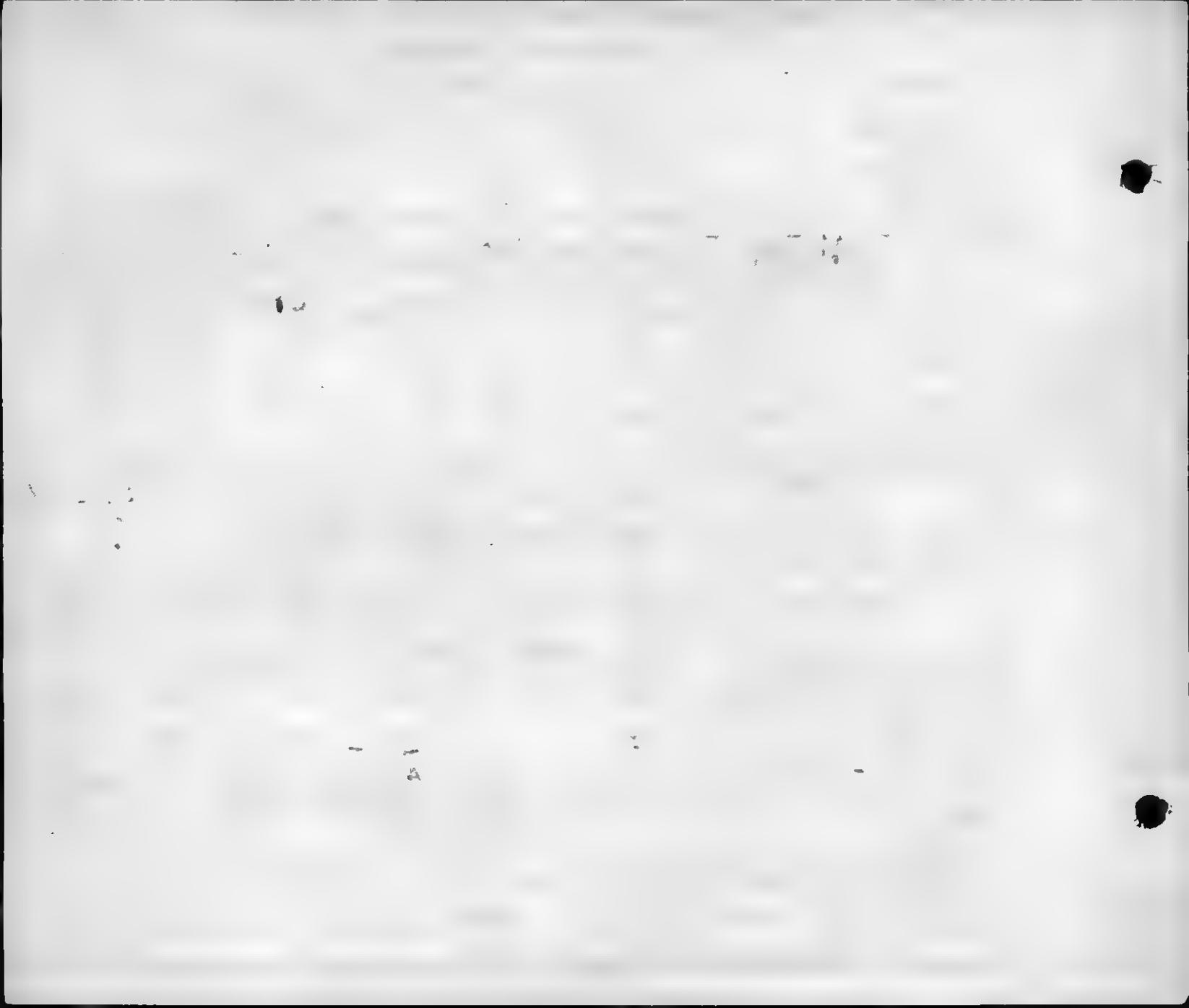
8776

CERTIFICATE OF DEATH

08737

Reg. Dist. No.

| | | | | | | |
|--|--|---|--|---|---|---------|
| 1. PLACE OF DEATH a. COUNTY BALTO. | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MD. | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROSEDALE | | c. LENGTH OF STAY IN 1b 11 YRS. | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7841 OAKDALE Ave. | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XROSEDALE | | | | |
| d. STREET ADDRESS 7841 OAKDALE AVE. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print) | First ELMER | Middle FRANKIN | Last BENTZ | | | |
| 4. DATE OF DEATH | Month AUG | Day 16 | Year 1959 | | | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH 3/22/1898 | | | |
| 9. AGE (In years from birthday) 61 | 10. IF UNDER 1 YEAR Months 0 | 11. IF UNDER 24 HRS. Days 0 | 12. IF UNDER 24 HRS. Hours 0 | | | |
| 13. FATHER'S NAME EARL BENTZ | 14. MOTHER'S MAIDEN NAME MARION COOKSEY | 15. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | |
| 16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) NO | 17. SOCIAL SECURITY NO. 217-03-1069 | 18. INFORMANT MAS. AGNES BENTZ 7841 OAKDALE AVE. | Address | | | |
| 19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion | | INTERVAL BETWEEN ONSET AND DEATH Sudden | | | | |
| 4.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Arteriosclerotic cardiovascular Disease | | DUE TO (c) | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Hour o. p. p. m. | Month Aug Day 15 Year 1959 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) BALTO. | 20f. (City or town) BALTO. | (County) | (State) |
| 21. I certify that I attended the deceased from Aug 1 1959 to Aug 16 1959 that I last saw the deceased alive on Aug 15 1959 , and that death occurred at 2 A.M. from the causes and on the date stated above. | | | | ADDRESS (Street, city or town, state) BALTO. 2A | DATE SIGNED 8/16/59 | |
| ACTUAL SIGNATURE G.M. Baumgardner | | | | PHYSICIAN'S NAME (Type) G.M. BAUMGARDNER | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 8/19/1959 | 22c. NAME OF CEMETERY OR CREMATORIAL GARDENS OF FAITH | 22d. LOCATION (City, town, or county) BALTO. | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE George W. Hoffmann | | ADDRESS 3218 Hudson St. | 24a. REC'D BY REGISTRAR 1959 | | 24b. REGISTRAR'S SIGNATURE Caroline L. Krause | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8777 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

05738

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certifying medical examiner by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

| | | | |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY BALTO. | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE M.D. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ESSEX | | c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 4 ESSEX | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 613 FRANKLIN AVE. | | d. STREET ADDRESS 613 FRANKLIN AVE. | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) CHARLES | | First L | Middle BETZ |
| 4. DATE OF DEATH Month AVG. | | Day 4 | Year 1959 |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH AUG 12 1877 |
| 9. AGE (In years at birthday) 81 yrs. | | 10. IF UNDER 1 YEAR Months 11 | 11. IF UNDER 24 HRS Hours 11 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED | | 10b. KIND OF BUSINESS OR INDUSTRY PENN R.R. | |
| 11. BIRTHPLACE (State or foreign country) BALTO. MD. | | 12. CITIZEN OF WHAT COUNTRY? MARY SCHIRMER | |
| 13. FATHER'S NAME JACOB BETZ | | 14. MOTHER'S MAIDEN NAME MARY SCHIRMER | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no, or unknown) — | | 16. SOCIAL SECURITY NO. — | |
| 17. INFORMANT (If yes, give name or dates of service) — | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 45-21 DUE TO Conditions, if any, which gave rise to immediate cause (b) CORONARY Occlusion DUE TO (c) ASC-V DISEASE | |
| 19. MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH — | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. — | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) — | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — |
| 20f. (City or town) — | | (County) — | |
| (State) — | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE M. B. Davis | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) M. B. Davis M.D. | | DATE SIGNED 8/6/59 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 8/7/59 | 22c. NAME OF CEMETERY OR CREMATORIAL CATH LAWN |
| 22d. LOCATION (City, town, or county) BALTO. MD. | | (State) — | |
| 23. FUNERAL DIRECTOR'S SIGNATURE John J. Connelly | | ADDRESS 418 Eastern Ave. | 24a. REC'D BY REGISTRAR DATE AUG 11 '59 |
| | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |



HOSPITAL OR CLINIC: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

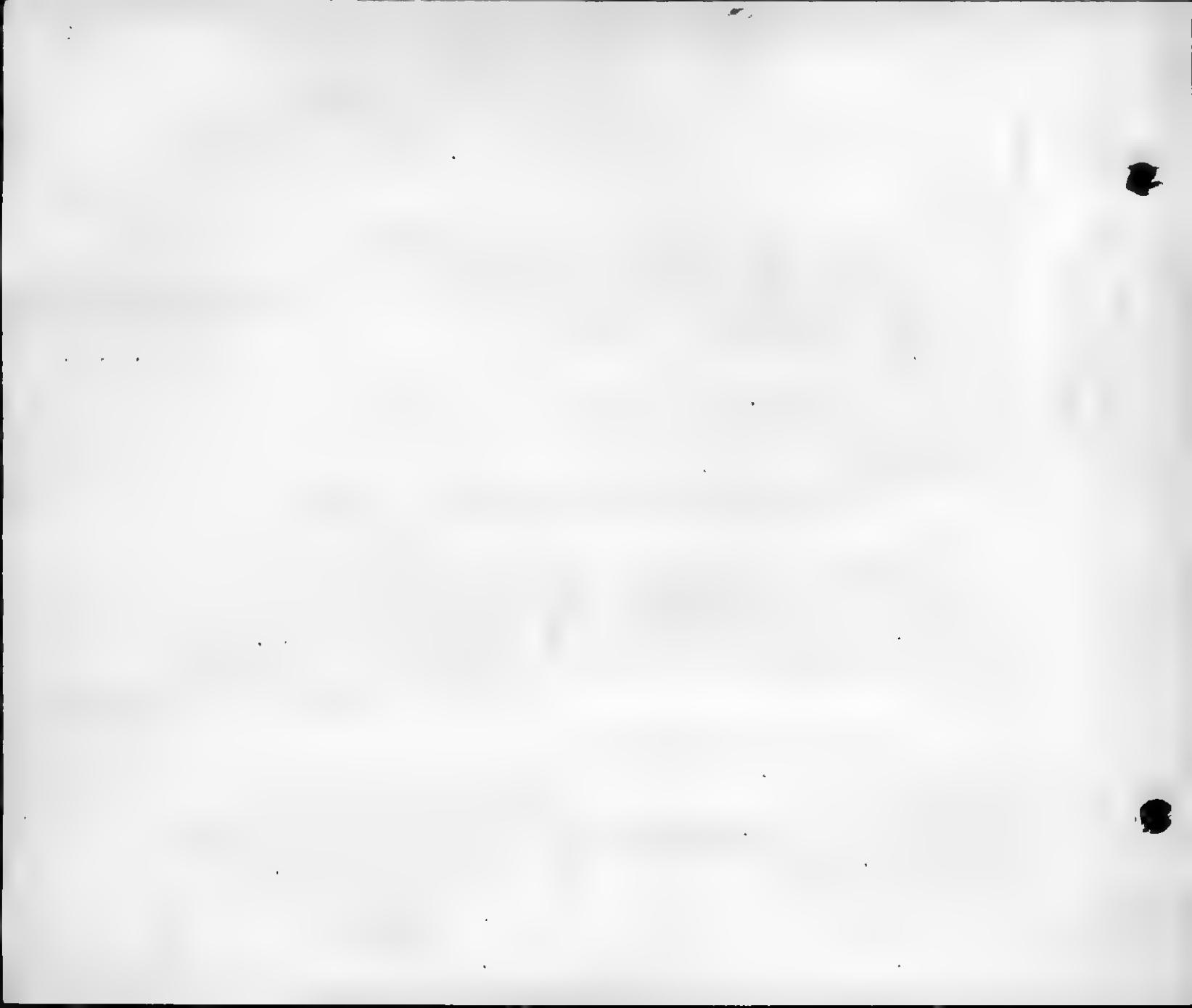
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8778 CERTIFICATE OF DEATH

08739

Reg. Dist. No.

| | | | |
|---|---------------------------|--|-----------------------------------|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | c. LENGTH OF STAY IN lb 11yr4mth6dys | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | |
| 3. NAME OF DECEASED (Type or print) Frank | | d. STREET ADDRESS 52 Spring Street | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Jan. 15, 1905 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) machinist | | 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) New York | |
| 13. FATHER'S NAME Antonia Bicchiri | | 12. CITIZEN OF WHAT COUNTRY U. S. A. | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown | | 16. SOCIAL SECURITY NO Unknown | |
| 17. INFORMANT Records: SPRING GROVE STATE HOSPITAL | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. | | INTERVAL BETWEEN ONSET AND DEATH 7 days | |
| (b) DUE TO | | Cardio vascular Accident 20 days | |
| (c) DUE TO | | Generalized Arteriosclerosis Several yrs | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 1. Diabetes Mellitus 2. benign Prostatic Hypertrophy | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from July 27, 1959, to August 17, 1959, that I last saw the deceased alive on August 17, 1959, and that death occurred at 7:30 A.M. from the causes and on the date stated above | | ADDRESS (Street, city or town, state) DATE SIGNED | |
| ACTUAL SIGNATURE <u>Edward T. Schnoor</u> M.D. SPRING GROVE STATE HOSPITAL | | 8-18-59 | |
| PHYSICIAN'S NAME (Type) <u>Edward T. Schnoor, M.D.</u> | | Catonsville 28, Maryland | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 8/19/59 | | 22b. DATE THEREOF Cathedral | |
| 22c. NAME OF CEMETERY OR CREMATORIAL Cathedral | | 22d. LOCATION (City, town, or county) Baltimore | |
| 23. FUNERAL DIRECTOR'S SIGNATURE J. J. Sather Sons | | ADDRESS 1318 Light St. | |
| 24a. REC'D BY REGISTRAR DATE AUG 20 '59 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kline | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-travel permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

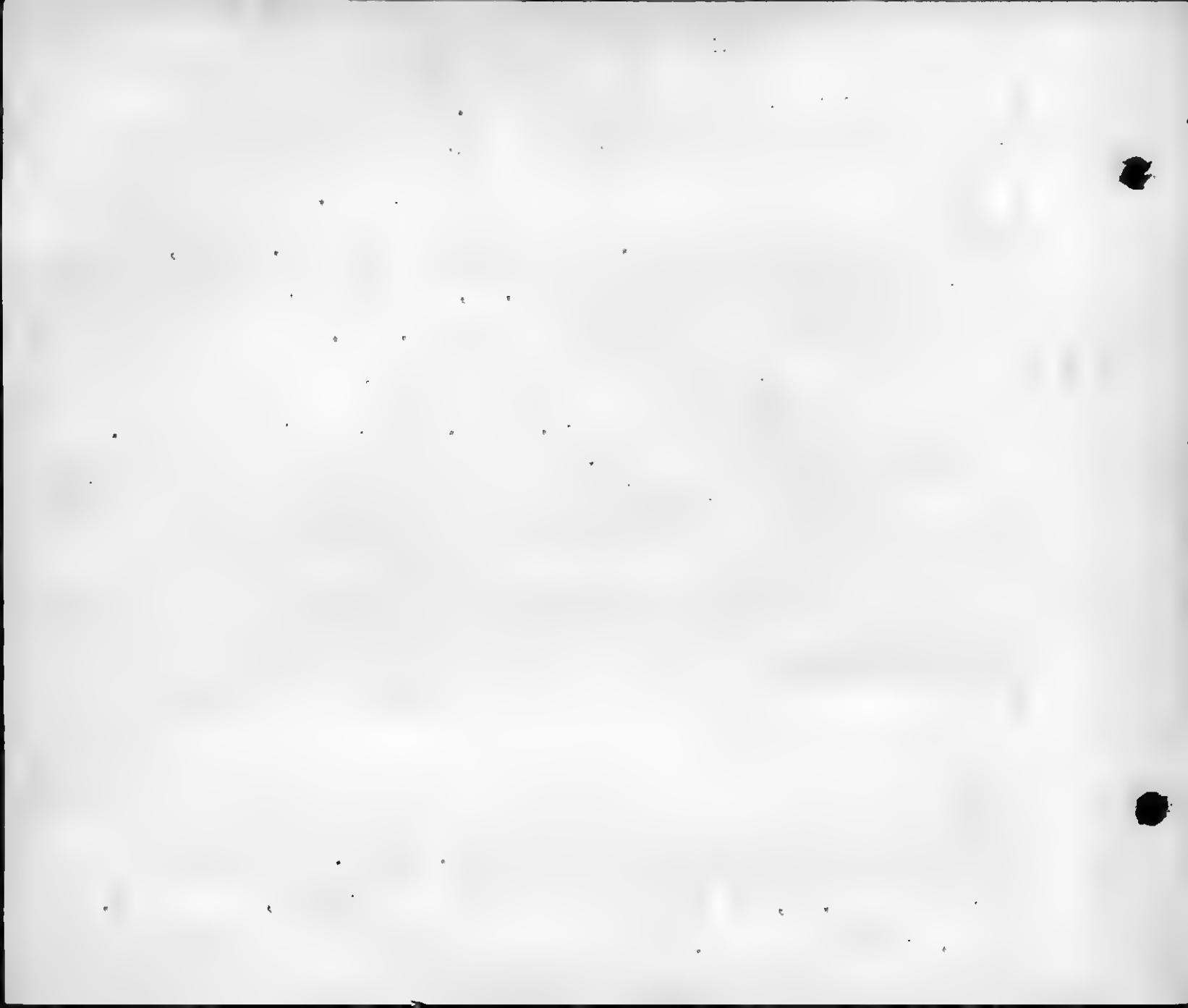
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15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8779 CERTIFICATE OF DEATH

Reg. Dist. No. 08740

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore | | 2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Md. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catoctinville | | c. LENGTH OF STAY IN 1b 3 months | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION House in The Pines | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | |
| 3. NAME OF DECEASED (Type or print) Lucy | | 4. DATE OF DEATH Aug. 20, 1959 | |
| 5. SEX Female | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Oct. 26, 1872 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Loudon Co. Va. | |
| 13. FATHER'S NAME Americas James Souder | | 14. MOTHER'S MAIDEN NAME Jane Frazier | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 17. INFORMANT Mrs. Jane B. Worthington 4332 Roland Ave. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 1 day | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Jan , 1950, to Aug 20 1959 , that I last saw the deceased alive on 8/18 1959 , and that death occurred at 7:30 P M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>R. Maurice Fieldman</i> | | ADDRESS (Street, city or town, state) 2 E. Read St. Baltimore Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Aug. 22, 1959 | |
| 22c. NAME OF CEMETERY OR CREMATORIAL Woodlawn | | 22d. LOCATION (City, town, or county) Baltimore (State) Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE John O. Mitchell & Sons Inc. | | ADDRESS 1900 Eutaw Place | |
| 24a. REC'D BY REGISTRAR DATE 24 2 '59 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Koenig | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

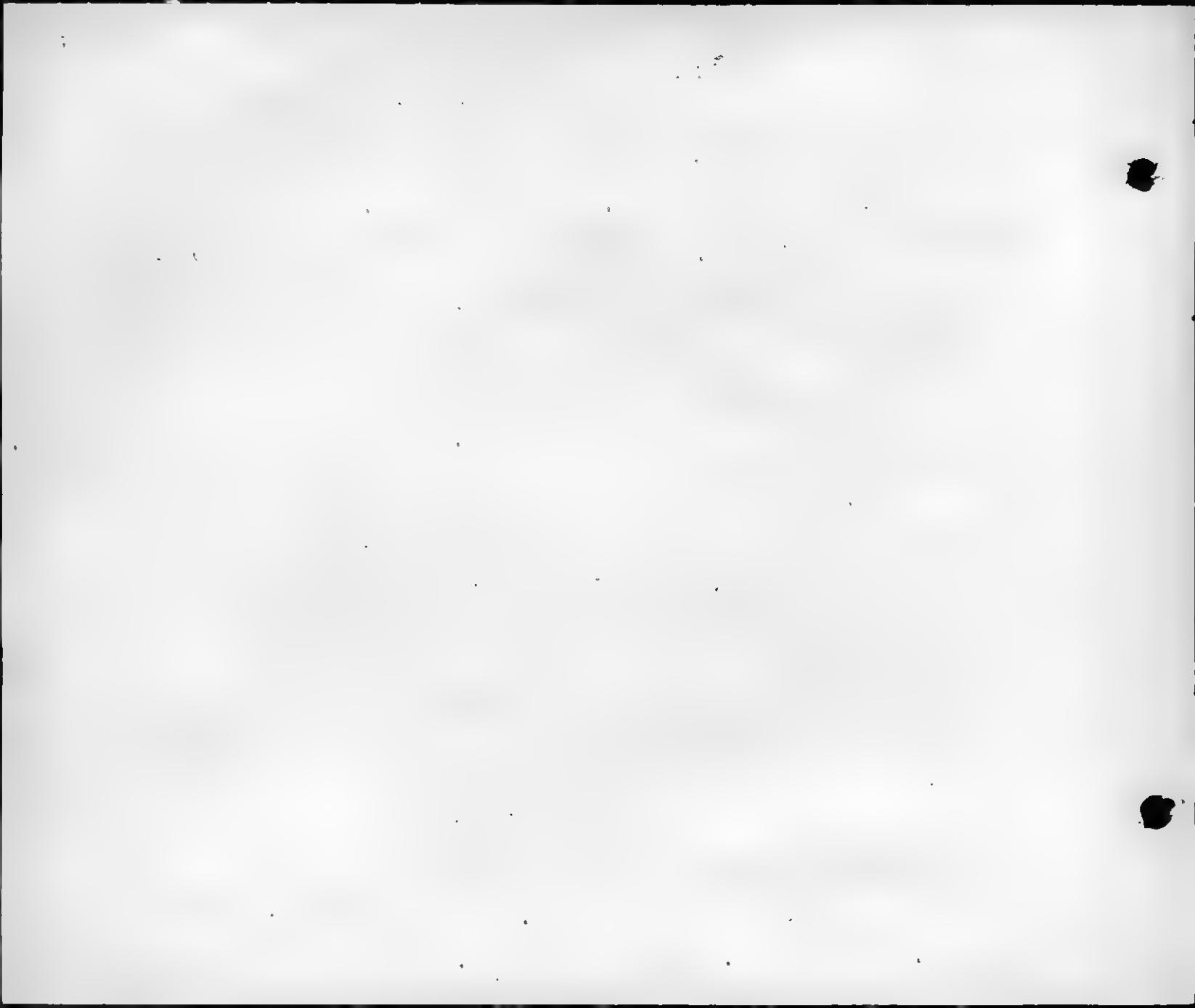
8780

CERTIFICATE OF DEATH

08741

Reg. Dist. No.

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore | | 2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Virginia | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crocker Farm, Ridge Rd. | | c. LENGTH OF STAY IN 1b 4 mths | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crocker Farm, Ridge Rd. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | First Alice | Middle B. | Last Blades |
| 4. DATE OF DEATH August 29, 1959 | Month Day Year 19 | | |
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH June 19, 1878 |
| 9. AGE (In years laid birthday) yrs. 87 | 10. USUAL OCCUPATION (Give kind of work done during 1958 if working, even if retired) housewife | 11. KIND OF BUSINESS OR INDUSTRY none | 12. BIRTHPLACE (State or foreign country) Mississippi |
| 13. FATHER'S NAME Charles McClain | 14. MOTHER'S MAIDEN NAME Mattie Brown | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | |
| 16. SOCIAL SECURITY NO. none | 17. INFORMANT Charles E. McClain 4830 Kurtz Rd, McLean, Va. | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) HYPERTENSIVE - ARTERIOSCLEROTIC C. V. DUE TO (c) DISEASE WITH CARDIAC DECOMPENSATION 3 YRS | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from MAY 15TH, 1956 , to AUGUST 29, 1959 , that I last saw the deceased alive on AUGUST 29, 1959 , and that death occurred at 6:45 AM , from the causes and on the date stated above. ACTUAL SIGNATURE Martin E. Strobel ADDRESS (Street, city or town, state) 48 Main St. KESTERSTOWN DATE SIGNED 8/29/59 PHYSICIAN'S NAME (Type) MARTIN E. STROBEL | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF Sept 1, 1959 | 22c. NAME OF CEMETERY OR CREMATORIAL Lorraine Cemt. | 22d. LOCATION (City, town, or county) Baltimore, Maryland (State) |
| 23. FUNERAL DIRECTOR'S SIGNATURE John A. Moran | ADDRESS 3000 E. Baltimore St, Baltw. | 24a. REC'D BY REGISTRAR DATE SEP 1 '59 | 24b. REGISTRAR'S SIGNATURE Arthur S. Hanna |



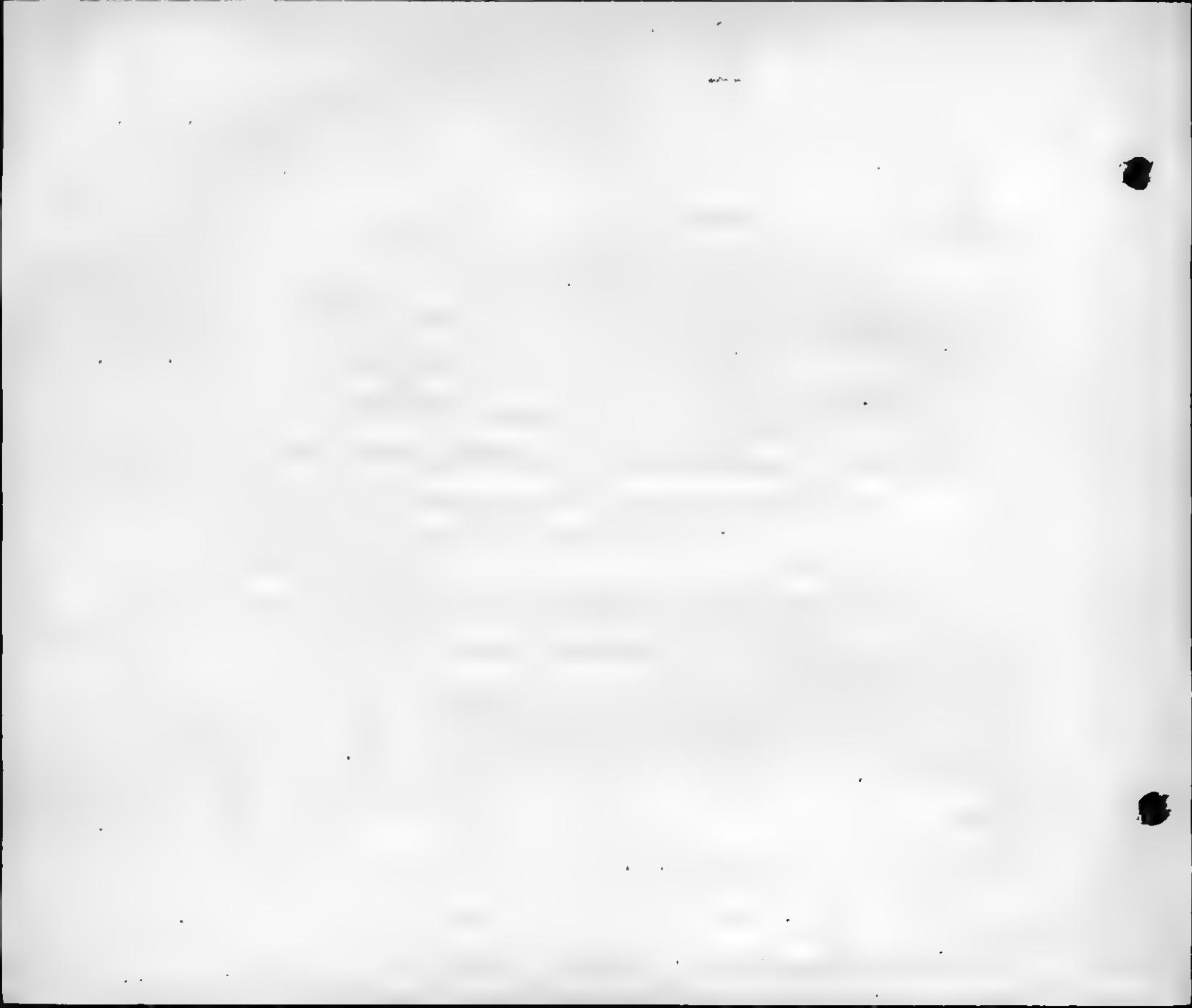
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08742

8781 CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | c. LENGTH OF STAY IN 1b 1mth10d6s | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West Hyattsville, Md. | |
| 3. NAME OF DECEASED (Type or print) First Clarence Middle Bodkin | | d. STREET ADDRESS 5806 - 33rd Place | |
| 4. DATE OF DEATH August 28 1959 | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 5. SEX male white | | 6. COLOR OR RACE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> April 19, 1877 | |
| 9. AGE (In years last birthday) 82 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired B & O Railroad Terminal | |
| 11. BIRTHPLACE (State or foreign country) West Virginia | | 12. CITIZEN OF WHAT COUNTRY U. S. A. | |
| 13. FATHER'S NAME Joseph B. Bodkin | | 14. MOTHER'S MAIDEN NAME Cynthia Cutlip | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. Unknown 17. INFORMANT Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 | | INTERVAL BETWEEN ONSET AND DEATH | |
| DUE TO Arteriosclerotic cardiovascular disease | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Generalized arteriosclerosis | | | |
| DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from July 24, 1959, to Aug. 28, 1959, that I last saw the deceased alive on Aug. 28, 1959, and that death occurred at 9:00a M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Stella Wachsler M.D. SPRING GROVE STATE HOSPITAL 8-28-59 | | | |
| 22a. PHYSICIAN'S NAME (Type) Stella Wachsler, M. D. | | 22b. CEMETERY OR CREMATORIUM Fort Lincoln Cemetery | |
| 22c. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22d. LOCATION (City, town, or county) Colmar Manor, Md. (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE F. Gachs Sons | | 24a. ADDRESS F. Gachs Sons, Hyattsville, Md. | |
| 24b. REC'D BY REGISTRAR Date SEP 1 '59 | | 24c. REGISTRAR'S SIGNATURE Cuthbert & Sons | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8782

CERTIFICATE OF DEATH

Reg. Dist. No.

13743

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore | | 2. USUAL RESIDENCE (Where deceased lived - If institution, Residence before admission) a. STATE Maryland | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard | | c. LENGTH OF STAY IN 1b 127 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | |
| 3. NAME OF DECEASED (Type or print) John | | First (None) | Middle Booker |
| 4. DATE OF DEATH August 29 1959 | | Month August | Day 29 |
| 5. SEX Male | | 6. COLOR OR RACE Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 8. DATE OF BIRTH June 25, 1893 | | 9. AGE (In years lost birthday) 66 87 yrs | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter | | 10b. KIND OF BUSINESS OR INDUSTRY Construction | |
| 11. BIRTHPLACE (State or foreign country) Louisville, Kentucky | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME John Booker | | 14. MOTHER'S MAIDEN NAME Name Unknown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO. HW 1 218-01-6106 | |
| 17. INFORMANT Clin Records, Vet. Adm Hosp, Ft. Howard, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL VASCULAR ACCIDENT (AREA OF SOFTENING IN DUE TO THE LEFT PARIETAL LOBE) Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) | | | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from April 24, 1959, to August 29, 1959, and attended him/her until death , and that death occurred on 11:25 A.M., from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>Ronald A. Oursler</i> | | ADDRESS (Street, city or town, state) M.D. VAH, Fort Howard, Maryland DATE SIGNED 8/29/59 | |
| PHYSICIAN'S NAME (Type) DAVID A. OURSLER, M.D. | | VAH, Fort Howard, Maryland 8/29/59 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 9/3/59 | |
| 22c. NAME OF CEMETERY OR CREMATORIAL Baltimore National | | 22d. LOCATION (City, town, or county) Baltimore, Maryland (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Arlington S. Phillips Funeral Director 1808-10 N. Monroe St. Balto 17, Md. | | ADDRESS | |
| | | 24a. REC'D BY REGISTRAR DATE SEP 8 '59 | |
| | | 24b. REGISTRAR'S SIGNATURE <i>Charles S. Kraus</i> | |



1

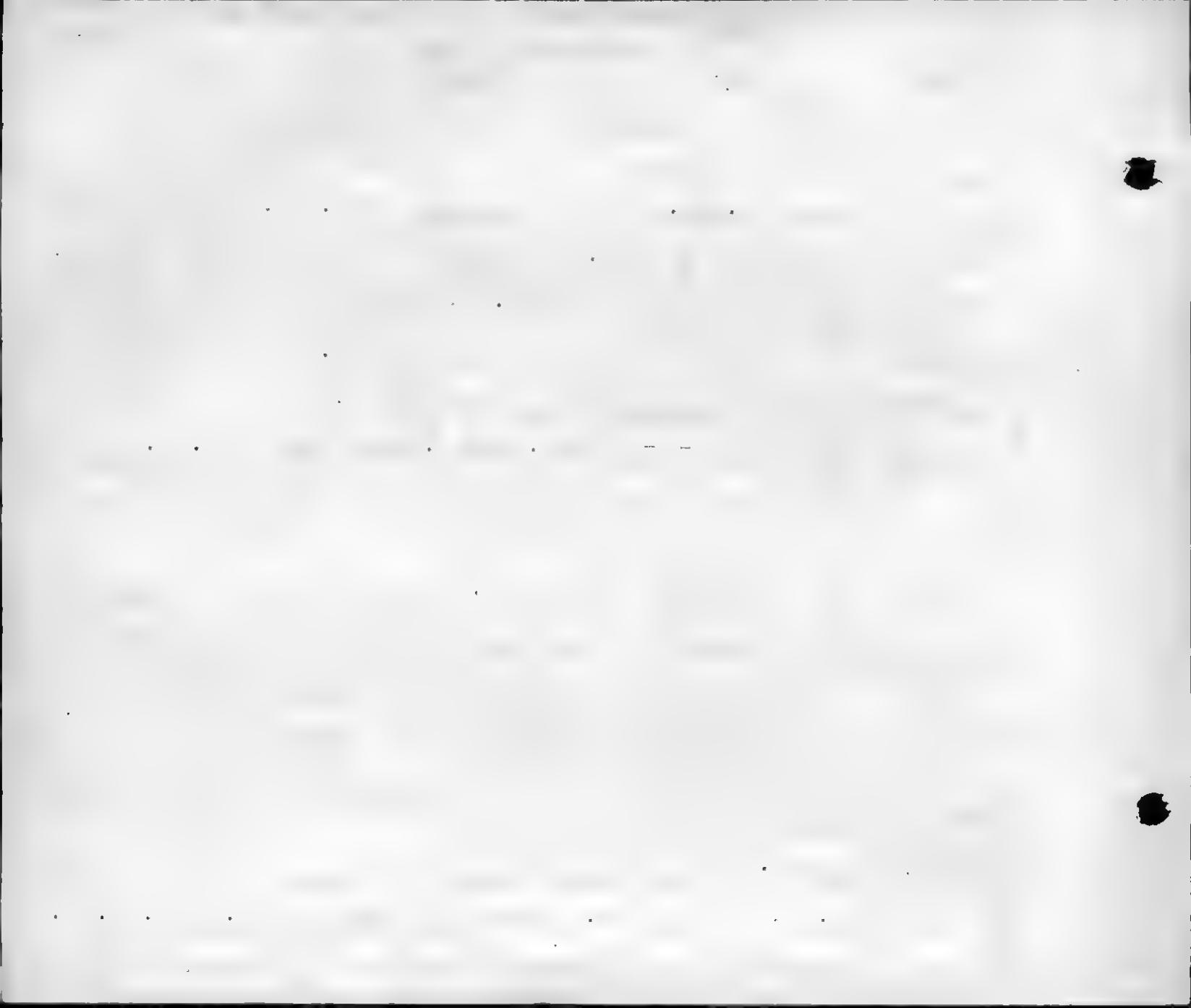
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8783 CERTIFICATE OF DEATH

08744

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|--|-------------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rosedale | c. LENGTH OF STAY IN 1b Rosedale | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rosedale | d. STREET ADDRESS 8419 Phila. Rd. |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8419 Phila. Rd. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Howard | First Middle E. | Last Boone | 4. DATE OF DEATH Month August Day 24, 1959 |
| S. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Jan. 23, 1883 |
| 9. AGE (In years at birthday) 76 yrs. | | 10. IF UNDER 1 YEAR Months 0 | 11. IF UNDER 24 HRS Days 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager-Retired | | 10b. KIND OF BUSINESS OR INDUSTRY Bank | 11. BIRTHPLACE (State or foreign country) Baltimore, Md. |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | |
| 13. FATHER'S NAME Edward Boone | | 14. MOTHER'S MAIDEN NAME Lavinia Harris | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 17. INFORMANT 215-91-9110 Mrs. Ethel J. Boone 8419 Phila. Rd. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. | | INTERVAL BETWEEN ONSET AND DEATH | |
| (b) DUE TO Myocardial Infarction | | | |
| (c) Chelosclerosis | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour o. m. p. m. | Month 19 | 20d. INJURY OCCURRED White at work <input type="checkbox"/> at war <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>Aug. 12, 1959</u> to <u>Aug. 21, 1959</u> that I last saw the deceased alive on <u>Aug. 12, 1959</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE John G. Orth | | ADDRESS (Street, city or town, state) Rosedale Medical Group. DATE SIGNED | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Aug. 27, 1959 | 22c. NAME OF CEMETERY OR CREMATORIAL Zion Evan. Lutheran |
| 22d. LOCATION (City, town, or county) Golden Ring Rd. Balto. Co. Md. | | (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Lassahn Funeral Home | | ADDRESS 7401 Belair Rd. | 24a. REC'D BY REGISTRAR DATE Aug. 26 '59 |
| | | | 24b. REGISTRAR'S SIGNATURE Cather & Kunk |



may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8784

CERTIFICATE OF DEATH

08745

Reg. Dist. No.

| | | | |
|--|------------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE MARYLAND b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COCKEYNSVILLE | c. LENGTH OF STAY IN lb 5 YEARS | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X BALTIMORE | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MASONIC HOME | | d. STREET ADDRESS 1429 ROSEWICK AVE | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) SARAH | First B | Middle BOULDEN | 4. DATE OF DEATH AUGUST 11 1959 |
| S. SEX FE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 11-16-1879 |
| 9. AGE (in years last birthday) 79 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 13. FATHER'S NAME RICHARD S. HALL | | 14. MOTHER'S MAIDEN NAME SUSANNAH SMITH | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) No | | 16. SOCIAL SECURITY NO. 215-22-0817 | |
| 17. INFORMANT Frank X. Smith Jr. Cockeysville, Md | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio Sclerotic Cardio</u> | | INTERVAL BETWEEN ONSET AND DEATH | |
| 4. <u>4/11</u> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last (b) <u>Vascular Disease</u> | | 5 years. | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>7/29</u> , 1959, to <u>8/11</u> , 1959, that I last saw the deceased alive on <u>8/11</u> , 1959, and that death occurred at <u>1:15 P.M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Elizabeth B. Sherrill</u> | | ADDRESS (Street, city or town, state) <u>Cockeysville, Md</u> DATE SIGNED <u>8/11/59</u> | |
| PHYSICIAN'S NAME (Type) <u>Elizabeth B. Sherrill</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 8-14-59 | |
| 22c. NAME OF CEMETERY OR CREMATORIUM Freeland Cemetery | | 22d. LOCATION (City, town, or county) Freeland, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul Street | | 24a. REC'D BY REGISTRAR AUG 13 1959 | |
| | | 24b. REGISTRAR'S SIGNATURE <u>Frank J. Smith</u> | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8762 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

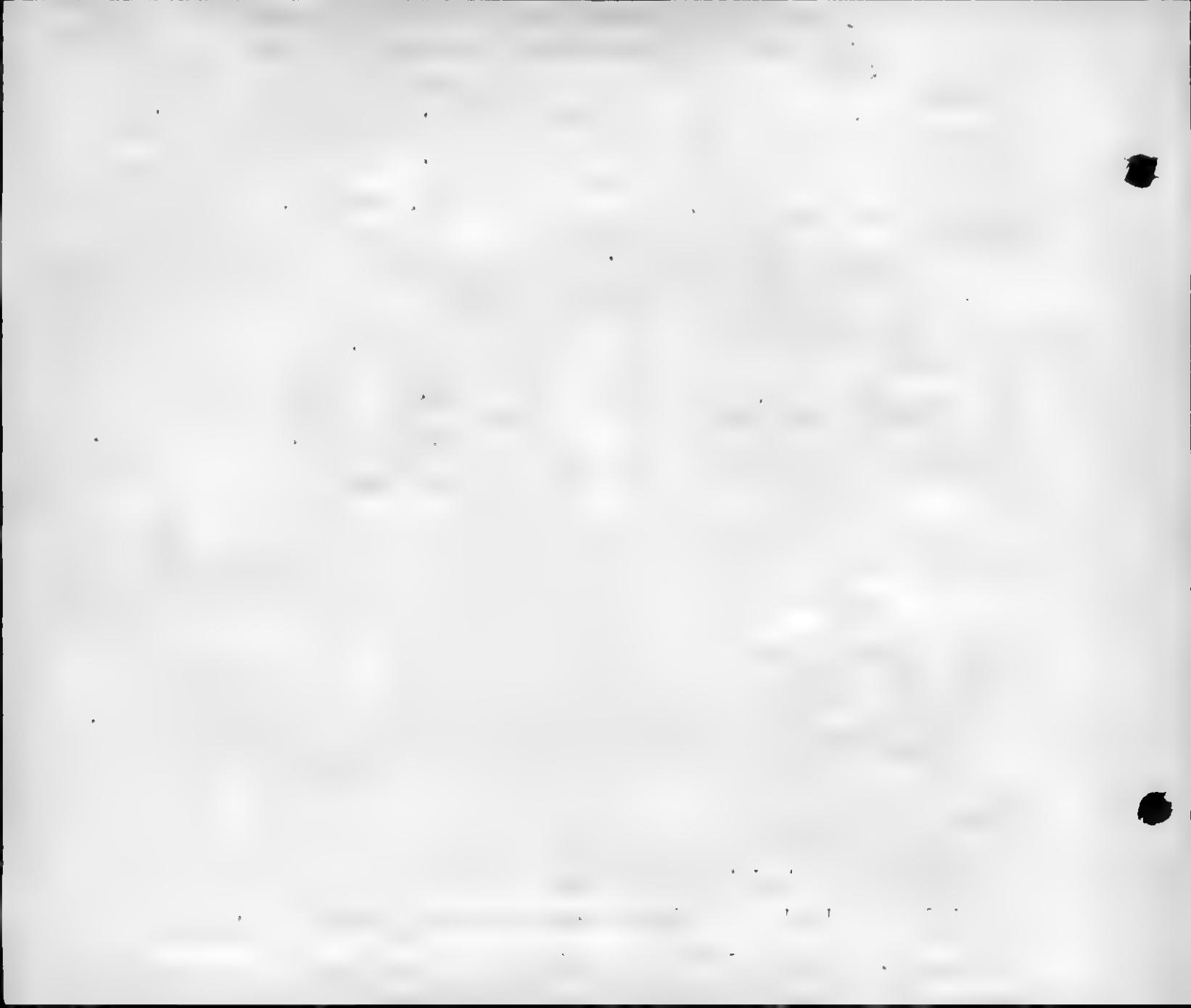
08746

Reg. Dist. No.

| | | | |
|---|-----------------------|--|-----------------------------|
| 1. PLACE OF DEATH a. COUNTY Balto. | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus | | c. LENGTH OF STAY IN 1b Balto. | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Blue Den Lake Benson Ave. | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Balto. | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Thurman R. Bozeman Jr. | | 4. DATE OF DEATH 8/26/59 Month Day Year 8 26 59 | |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 5/17/44 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student | | 11. BIRTHPLACE (State or foreign country) Portsmouth Va. | |
| 13. FATHER'S NAME Thurman Bozeman Sr. | | 14. MOTHER'S MAIDEN NAME Cleo XXXXX Dorothy Weber | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. 17. INFORMANT Thurman R. Bozeman Sr. Portsmouth, Va. | |
| Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 729.8 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) | | | |
| DUE TO accident | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) while swimming in lake | |
| 20c. TIME OF INJURY Month, Day, Year 3/26/59 10:20 pm 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) lake | | 20f. (City or town) Arbutus, Balto, | |
| | | (County) Md. (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE <i>Geo. S.M. Kieller</i> | | D.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | |
| DATE SIGNED 8/27/59 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 8/29/59 | |
| 22c. NAME OF CEMETERY OR CREMATORIAL Olive Branch Cemetery | | 22d. LOCATION (City, town, or county) Portsmouth, Virginia (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard 4107 Wilkens Avenue | | ADDRESS | |
| | | 24a. REC'D BY REGISTRAR DATE SEP 1 '59 | |
| | | 24b. REGISTRAR'S SIGNATURE <i>Geo. S. Kieller</i> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Page 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8785

CERTIFICATE OF DEATH

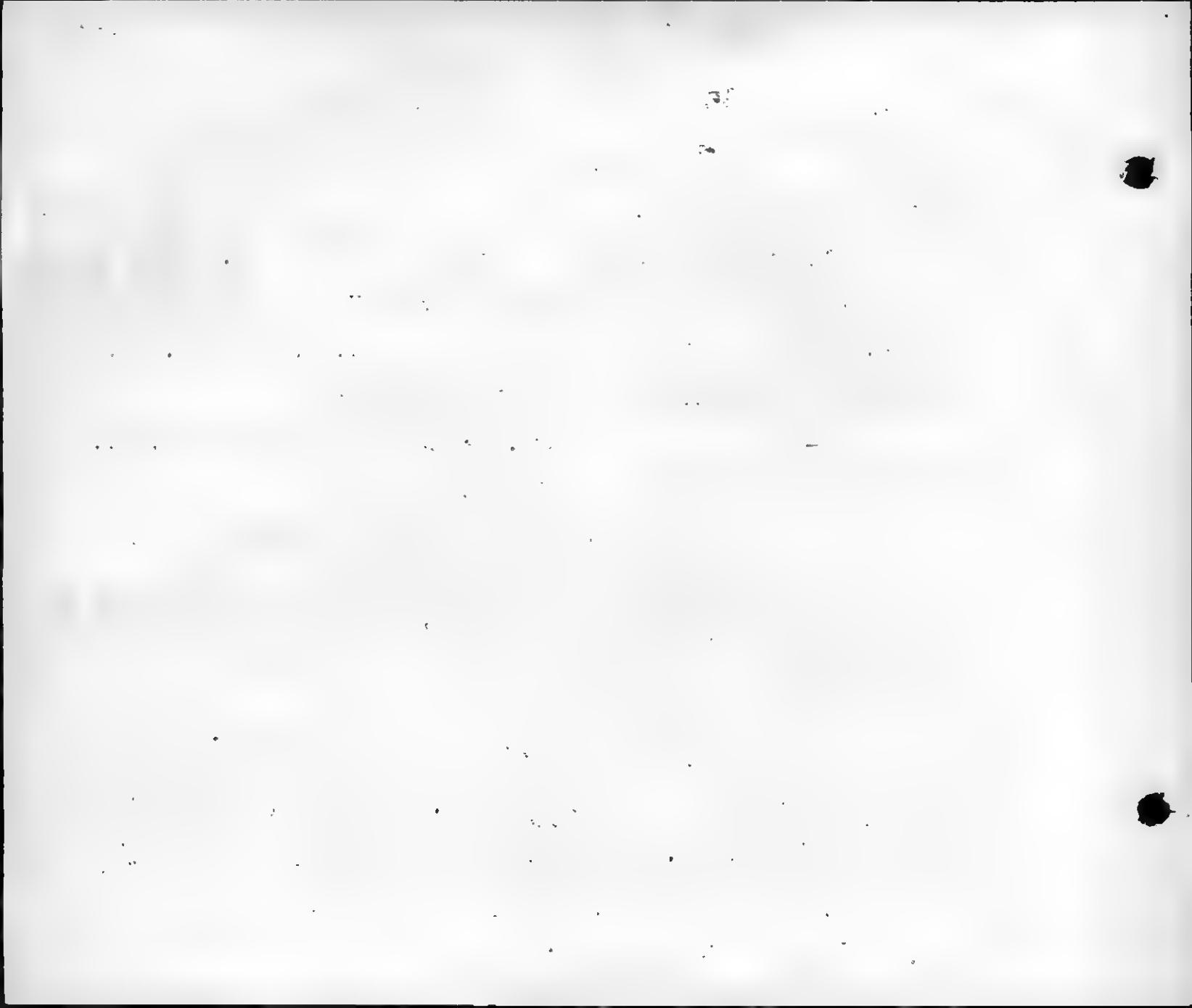
Reg. Dist. No.

08747

TO HOSPITAL OR ENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|--|--|--|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore | | 2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson | | c. LENGTH OF STAY IN 1b 2 years | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Towson Convalescent Home | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jarrettsville | |
| 3. NAME OF DECEASED (Type or print) Lillian | | First Nelson | Middle Brown |
| 4. DATE OF DEATH Aug. 24, 1959 | | Month Aug. | Day 24 |
| 5. SEX Female | | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 8. DATE OF BIRTH Mar. 24, 1887 | | 9. AGE (in years lost birthday) 72 | 10. IF UNDER 1 YEAR Months 0 |
| 10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Home | 11. BIRTHPLACE (State or foreign country) Jarrettsville, Md. |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Charles Watters Amoss | |
| 14. MOTHER'S MAIDEN NAME Laura Nelson | | 15. SOCIAL SECURITY NO 16. SOCIAL SECURITY NO | |
| 16. INFORMANT Mrs. Lee Kee | | 17. ADDRESS Jarrettsville, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 122.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. DUE TO (b) DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH <i>Chronic Myocarditis</i> <i>Arteriosclerotic Cardio-Vascular Disease</i> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) PARKINSONISM; MALNUTRITION | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACC DENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from January 22, 1959 , to Aug 24, 1959 , that I last saw the deceased alive on Aug. 21, 1959 , and that death occurred at 4:30 P.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>H. V. Harbold</i> | | ADDRESS (Street, city or town, state) 4706 Harbold Rd | |
| PHYSICIAN'S NAME (Type) <i>H. V. HAR BOLD M.D.</i> | | DATE SIGNED Aug. 24, 1959 | |
| 22a. BL R AL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 8/27/1959 | |
| 22c. NAME OF CEMETERY OR CREMATORIAL Jarrettsville | | 22d. LOCATION (City, town, or county) Jarrettsville | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Charles E. Kutz</i> | | 24a. REC'D BY REGISTRAR DATE AUG 28 1959 | |
| ADDRESS <i>Jarrettsville Md.</i> | | 24b. REGISTRAR'S SIGNATURE <i>Charles E. Kutz</i> | |



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

8786

CERTIFICATE OF DEATH

Reg. Dist. No.

08748

| | | | | | | | | |
|--|--|--|---|--|---|--|----------------------------------|--------------|
| 1. PLACE OF DEATH a. COUNTY Balto. | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. | | b. COUNTY Balto. | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | d. STREET ADDRESS 8 Park Drive | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shady Nook Nursing Home | | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) Sarah | | First | Middle C. | Last Brown | 4. DATE OF DEATH Aug 31 | Month Aug | Day 31 | Year 1955 |
| 5. SEX F | | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH July 6, 1881 | 9. AGE (In years lost birthday) 78 yrs. | 10. IF UNDER 1 YEAR Months 0 | 11. IF UNDER 24 HRS Days 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk | | 10b. KIND OF BUSINESS OR INDUSTRY Ret Dept. Store | 11. BIRTHPLACE (State or foreign country) Md. | | 12. CITIZEN OF WHAT COUNTRY: | | | |
| 13. FATHER'S NAME George R. Curtis | | 14. MOTHER'S MAIDEN NAME Nancy Marchant | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) No | | 16. SOCIAL SECURITY NO. -- | | 17. INFORMANT Jos. D. Brown 8 Park Drive | | Address | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 17'X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) (c) | | Urinary dysfunctional Carcinoma of Cervix | | | | INTERVAL BETWEEN ONSET AND DEATH 6 weeks 3 months 18 months | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, and that death occurred at _____, M., from the causes and on the date stated above ACTUAL DATE Dr. L. A. Kochman M.D. ADDRESS (Street, city or town, state) Dr. L. A. Kochman M.D. DATE SIGNED 9/1/59 | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 9-2-59 | | 22b. DATE THEREOF 9-2-59 | | 22c. NAME OF CEMETERY OR CREMATORIUM Woodlawn Cem. | | 22d. LOCATION (City, town, or county) Woodlawn Ind. | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Ferley Funeral Home Catonsville Md. | | ADDRESS | | 24a. REC'D BY REGISTRAR DATE SEP 2 '59 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8787

CERTIFICATE OF DEATH

08749

Reg. Dist. No.

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) a. STATE MARYLAND b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COCKEYNSVILLE | c. LENGTH OF STAY IN 1b 2 YEARS | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MASONIC HOME | d. STREET ADDRESS LAFAYETTE & CHARLES | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) GEORGIE EHRMAN | First MIDDLE BURKE | 4. DATE OF DEATH AUG. 22 | Month Year 1959 |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 6-15-1877 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) MARYLAND |
| 12. CITIZEN OF WHAT COUNTRY U.S. | | 13. FATHER'S NAME GEORGE M. EHRMAN | |
| 14. MOTHER'S MASTEN NAME SARAH M. EICHLER | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | |
| 16. SOCIAL SECURITY NO. NONE | | 17. INFORMANT Frank L. Smith Jr. Cockeysville, Md | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio Sclerotic Cardiac 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Vascular Disease (c) | | INTERVAL BETWEEN ONSET AND DEATH 2 years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour a. m. p. m. | Month, Day, Year 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from July 22, 1959, to Aug. 22, 1959, that I last saw the deceased alive on Aug. 21, 1959, and that death occurred at 3:40 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Elizabeth B. Sherrill M.D. Cockeysville, Md. 8/22/59 DATE SIGNED | | | |
| ACTUAL SIGNATURE Elizabeth B. Sherrill | PHYSICIAN'S NAME (Type) Elizabeth B. Sherrill | 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | |
| 22b. DATE THEREOF 8-26-59 | 22c. NAME OF CEMETERY OR CREMATORIUM Woodlawn Cemetery | 22d. LOCATION (City, town, or county) Woodlawn, Md | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul Street | ADDRESS | 24a. REC'D BY REGISTRAR DATE AUG 25 '59 | 24b. REGISTRAR'S SIGNATURE C. H. S. Hause |

TO HOSPITAL OR
may be retained
the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8788

CERTIFICATE OF DEATH

Reg. Dist. No.

08750

| | | | | | | | | |
|---|-----------------------|---|---------------------------------|--|--|---|--|---|
| 1. PLACE OF DEATH a. COUNTY BALTO | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MD | | b. COUNTY | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUTONSVILLE | | c. LENGTH OF STAY IN 1b 2 wks | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5743 EDMONDSON AVE | | e. STREET ADDRESS 1403 John St | | d. STREET ADDRESS | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) WILHELMINA P. BURROWS | | First | Middle | Last | 4. DATE OF DEATH Aug 27 | Month | Day | Year 1959 |
| 5. SEX F | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH NOV 27 1878 | 9. AGE (In years last birthday) 80 yrs | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NURSE'S AID | 11. KIND OF BUSINESS OR INDUSTRY WOMEN'S Hosp | 12. BIRTHPLACE (State or foreign country) GERMANY | 13. CITIZEN OF WHAT COUNTRY? USA |
| 14. FATHER'S NAME CARL J LOSCH | | 15. MOTHER'S MAIDEN NAME HENRIETTA HOFFMAN | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Family Records | | Address |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 434.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 8 hrs |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) This is not applicable. | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) This is not applicable. | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) BALTIMORE | | (County) (State) |
| 21. I certify that I attended the deceased from Aug 17, 1959, to Aug 27, 1959, that I last saw the deceased alive on Aug 26, 1959, and that death occurred at 3:45 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE CHARLES F. EVANS + SON | | | | | | ADDRESS (Street, city or town, state) 618 W. Mt. Royal Ave | | DATE SIGNED Sep 1 1959 |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 8-29-59 | | 22c. NAME OF CEMETERY OR CREMATORIAL NEW CATHEDRAL | | 22d. LOCATION (City, town, or county) BALTIMORE | | (State) MD |
| 23. FUNERAL DIRECTOR'S SIGNATURE CHARLES F. EVANS + SON | | ADDRESS 118 W. Mt. Royal Ave | | 24a. REC'D BY REGISTRAR DATE SEP 1 '59 | | 24b. REGISTRAR'S SIGNATURE Charles & Anna | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8789 CERTIFICATE OF DEATH

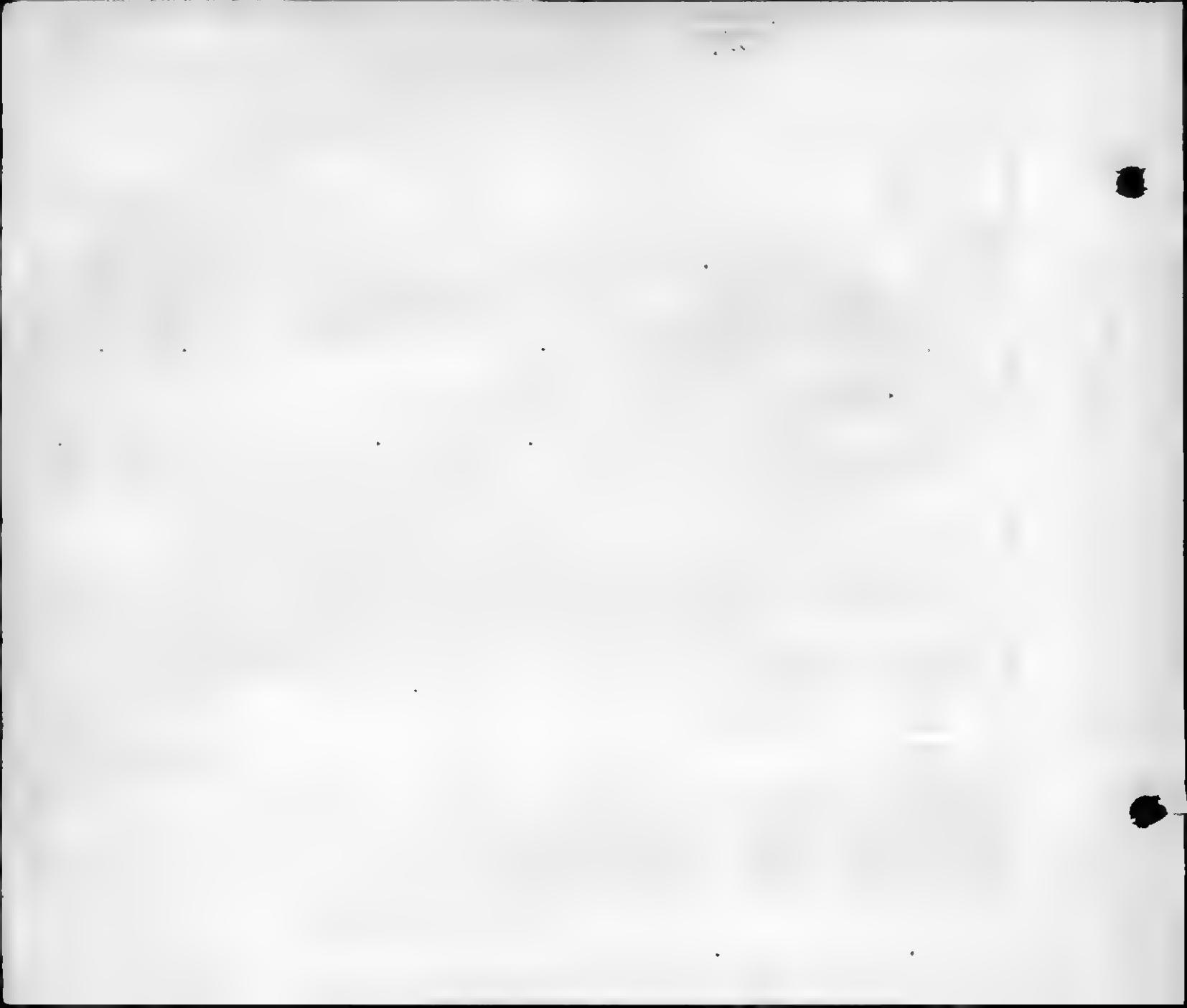
Reg. Dist. No. 05751

| | | | | | |
|---|--|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY | | Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) | |
| | | | | a. STATE Maryland | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. LENGTH OF STAY IN lb RURAL and give nearest town Baltimore Life | | b. COUNTY | |
| | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS Holly Hill Nursing Home 3932 Lowndes Avenue | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | | First James A. Cain | Middle | Last | 4. DATE OF DEATH Month Day Year August 17, 1959 |
| 5. SEX Male | | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | B. DATE OF BIRTH June 15, 1874 | 9. AGE (in years lost birthday) 85 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk | | 10b. KIND OF BUSINESS OR INDUSTRY Investment Co. Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME James A. Cain | | 14. MOTHER'S MAIDEN NAME Ann O'Dowd | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. Yes | | 17. INFORMANT Mrs. Marjory C. Cain-3932 Lowndes Ave. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 412.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c) | | After 1850's Atherosclerotic Cardiovascular Disease with Decompensation | | INTERVAL BETWEEN ONSET AND DEATH 5 yrs. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>April 1, 1947</u> to <u>Aug 19, 1959</u> that I last saw the deceased alive on <u>Aug. 11, 1949</u> , and that death occurred at <u>4 P. M.</u> from the causes and on the date stated above. | | | | ADDRESS (Street, city or town, state) John A. Moran J. M. D. 6011 York Rd. Baltimore, Maryland | |
| ACTUAL SIGNATURE John A. Moran J. M. D. | | | | DATE SIGNED 8/18/59 | |
| PHYSICIAN'S NAME (Type) John A. Moran J. M. D. | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 8/20/59 | | 22c. NAME OF CEMETERY OR CREMATORIUM New Cathedral Cemetery Baltimore, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE John A. Moran-3000 E. Baltimore Street | | ADDRESS | | 24a. REC'D BY REGISTRAR DATE AUG 20 '59 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Charles S. Hayes | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55



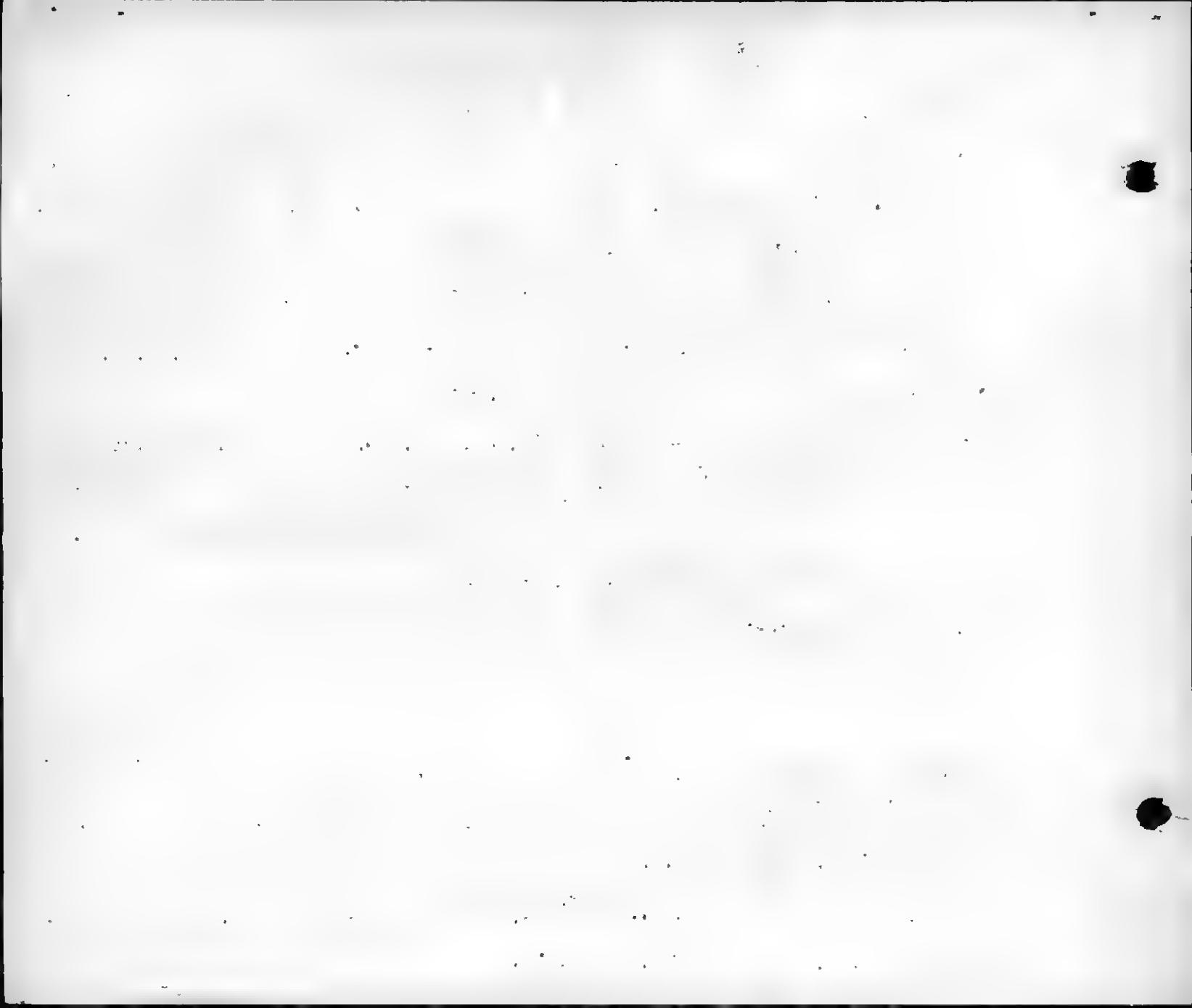
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08752

8790 CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|----------------------------------|---|---|--|---------------------------------------|---|------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Baltimore | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland | | b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard | | c. LENGTH OF STAY IN 1b 28 Days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | | d. STREET ADDRESS 3218 Dorithan Road (15) | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital | | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | First HENRY | Middle — | Last CAPLAN | 4. DATE OF DEATH August 10 1959 | Month August | Day 10 | Year 1959 |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | B. DATE OF BIRTH April 26, 1921 | 9. AGE (in years last birthday) 38 yrs | IF UNDER 1 YEAR Months 0 | IF UNDER 24 HRS Hours 0 | IF UNDER 24 HRS Min 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY Steel Company | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Max Caplan | | | | 14. MOTHER'S MAIDEN NAME SaraZabolnski | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO. 217-26-4804 | | INFORMANT Clin.Rec., Vet. Adm. Hospital, Ft. Howard, Maryland | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ADENOCARCINOMA, SIGMOID COLON 153.3 XXXXX Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) METASTATIC ADENOCARCINOMA, LIVER AND RETROPERITONEAL XXXXX LYMPH NODES (c) PULMONARY EMPHYSEMA, MARKED 6 MONTHS INTERVAL BETWEEN ONSET AND DEATH 6 MONTHS | | | | | | | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Exploratory Laparotomy; Colostomy 3/29/59 | | | | | | | |
| 20c. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b) | | | | | |
| 20c. TIME OF INJURY Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that VA attended the deceased from July 13 1959 to August 10 1959 and that death occurred at 10:40 AM from the causes and on the date stated above. ADDRESS (Street, city or town, state) John W. Crawford ACTUAL SIGNATURE M.D. VAH, FORT HOWARD, MARYLAND DATE SIGNED 8/10/59 | | | | | | | |
| PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, M.D. | | VAH, FORT HOWARD, MARYLAND | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 8-11-59 | | 22c. NAME OF CEMETERY OR CREMATORIAL Maryland Fred State Jewish War Vet. Memorial | | 22d. LOCATION (City, town, or county) Hamilton Ave., Baltimore, Md. (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Jack Lewis, Inc. 2100 Eutaw Pl., Balt., Md. | | ADDRESS | | 24a. REC'D BY REGISTRAR AUG 12 '59 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Trahan | |



TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8791 CERTIFICATE OF DEATH

Reg. Dist. No. 08754

| | | | |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY <i>Baltimore County, Maryland</i> | | 2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Glen Arm, Md.</i> | | c. LENGTH OF STAY IN 1b <i>3 years</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>None</i> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <i>Ada Lovella Christopher</i> | | First <i>Ada</i> | Middle <i>Lovella</i> |
| | | Last <i>Christopher</i> | 4. DATE OF DEATH <i>Aug. 11 1959</i> |
| 5. SEX <i>Female</i> | 6. COLOR OR RACE <i>White</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>MAR 11 1877</i> |
| 9. AGE (in years last birthday) <i>82 yrs</i> | | 10. UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>None</i> | |
| 10c. BIRTHPLACE (State or foreign country) <i>Philadelphia, Pa.</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>America</i> | |
| 13. FATHER'S NAME <i>Simmons</i> | | 14. MOTHER'S MAIDEN NAME <i>Ada L. Simmons</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>None</i> | |
| 17. INFORMANT <i>Mr Eugene R. Christopher</i> | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Insufficiency</i> DUE TO <i>Arterio Sclerotic Cardiovascular Disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>422.1</i> (b) DUE TO (c) | |
| 19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) <i>None</i> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Paroxysms of Agitation</i> <i>Arthritis</i> | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) <i>Kingsville, Md.</i> | |
| 21. I certify that I attended the deceased from <i>Nov. 10 1957</i> to <i>Aug. 9 1959</i> that I last saw the deceased alive on <i>Aug. 11 1959</i> , and that death occurred at <i>8:45 A.M.</i> from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) <i>Kingsville, Md.</i> DATE SIGNED <i>8-11-59</i> | |
| ACTUAL SIGNATURE <i>William A. Tyson</i> M.D. | | 22a. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | |
| 22b. DATE THEREOF <i>Aug 14, 1959</i> | | 22c. NAME OF CEMETERY OR CREMATORIAL <i>Moreland Memorial Park</i> | |
| 22d. LOCATION (City, town, or county) <i>Baltimore</i> | | (State) <i>Md.</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Henry W. Jenkins & Sons Co.</i> | | 24a. REC'D BY REGISTRAR DATE <i>AUG 14 '59</i> | |
| | | 24b. REGISTRAR'S SIGNATURE <i>Charles S. Knott</i> | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8792 CERTIFICATE OF DEATH

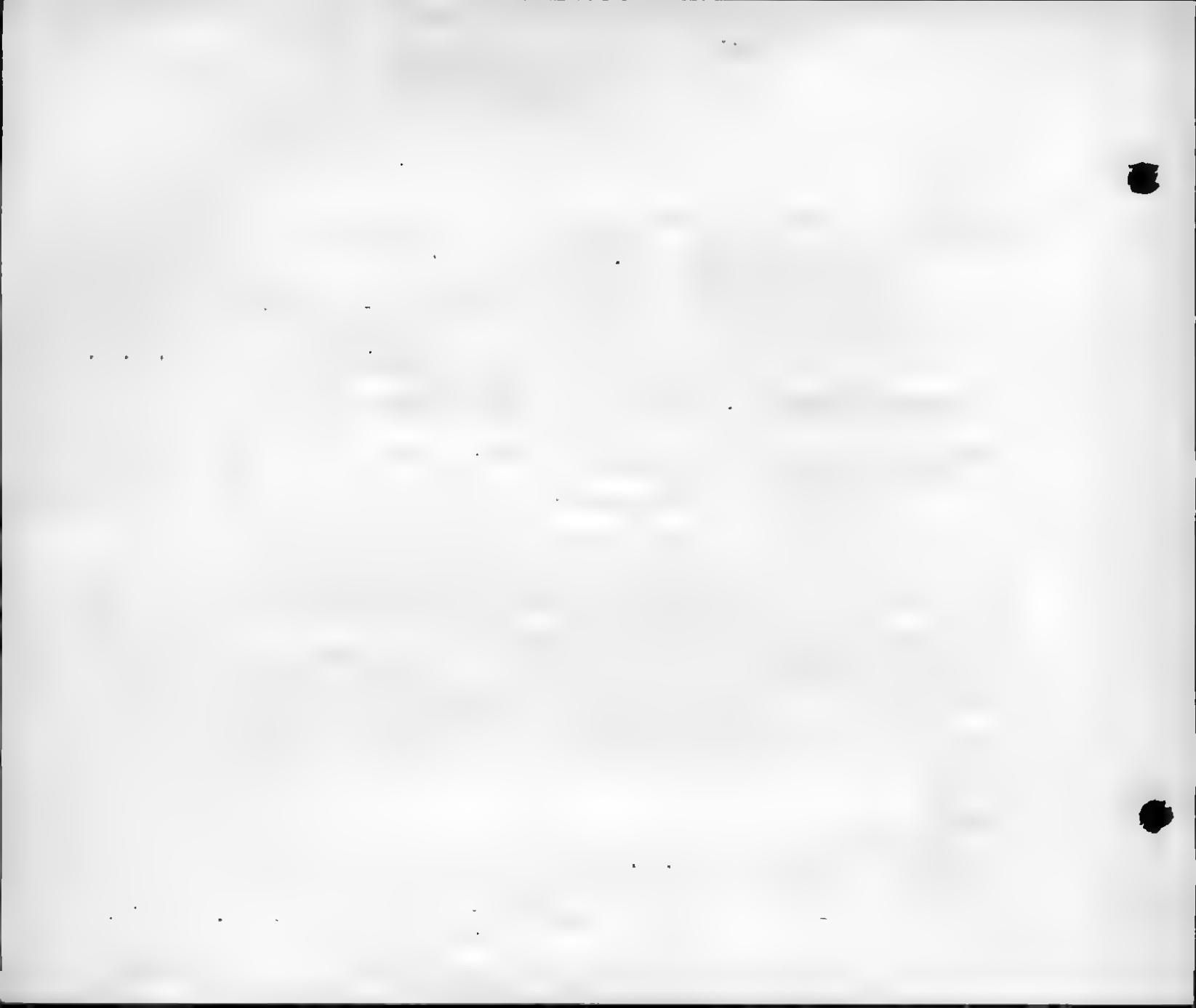
08755

Reg. Dist. No.

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE | |
| Baltimore MARYLAND | | Maryland | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | c. LENGTH OF STAY IN 1b 4 months | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Howard | | First Howard | Middle C. |
| 4. DATE OF DEATH | | Month August | Day 17 |
| 5. SEX male | | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |
| 8. DATE OF BIRTH XXXX 10-22-85 | | 9. AGE (In years last birthday) 87 3 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer | | 10b. KIND OF BUSINESS OR INDUSTRY railroad | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY U. S. A. | |
| 13. FATHER'S NAME XXXXXX Howard S. Cole | | 14. MOTHER'S MAIDEN NAME Mary Unknown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) XXXXXnd | | 16. SOCIAL SECURITY NO 215-0-47214 Has a card | |
| 17. INFORMANT Records: SPRING GROVE STATE HOSPITAL | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Encephalomalacia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause (b). DUE TO Cerebrovascular thromboses Cerebral; generalized arteriosclerosis DUE TO Pulmonary abscesses; unresolved pneumonia | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | INTERVAL BETWEEN ONSET AND DEATH 8 mo plus | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from July 29, 1959 to 8/17, 1959 that I last saw the deceased alive on 8/17, 1959, and that death occurred at 11:20 p.m. from the causes and on the date stated above ACTUAL SIGNATURE <i>Stella Wachsler</i> M.D. SPRING GROVE STATE HOSPITAL PHYSICIAN'S NAME (Type) Stella Wachsler, M. D. Catonsville 28, Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 8-20-59 | |
| 22c. NAME OF CEMETERY OR CREMATORIUM Black Rock Baptist | | 22d. LOCATION (City, town, or county) Butler, Md. (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Private Funeral Service | | 24a. REC'D BY REGISTRAR DATE AUG 20 '59 | |
| | | 24b. REGISTRAR'S SIGNATURE Arthur S. ... | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08756

CERTIFICATE OF DEATH

Reg. Dist. No

| | | | |
|---|-------------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk | c. LENGTH OF STAY IN 1b 16 years | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7465 Lawrence Road | | d. STREET ADDRESS 1930 Robinwood Road | |
| e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) EDITH | First SHAFFER | Middle CONLEY | Last Month Day Year August 17, 1959 |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH August 5, 1888 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Grafton, West Virginia | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME William L. Shaffer | | 14. MOTHER'S MAIDEN NAME Mary Jane Born | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No. | | 16. SOCIAL SECURITY NO. INFORMANT Mrs. Eileen Peters 7465 Lawrence Road | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 170 X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. DUE TO (b) DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH one month Carcinoma of Breast one year | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>July 1955</u> to <u>16 Aug. 1959</u> that I last saw the deceased alive on <u>16 Aug. 1959</u> , and that death occurred at <u>4 A.M.</u> from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) <u>2900 Dunham Rd</u> DATE SIGNED <u>8-17-59</u> | |
| ACTUAL SIGNATURE <u>Morris Rainess</u> M.D. | | PHYSICIAN'S NAME (Type) <u>MORRIS RAINESS, M.D.</u> <u>Dundalk 22</u> <u>Md.</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Aug. 20, 1959 | |
| 22c. NAME OF CEMETERY OR CREMATORIAL Oak Lawn Cemetery | | 22d. LOCATION (City, town, or county) (State) Colgate, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home 2112 Dundalk Ave. | | 24a. REC'D BY REGISTRAR DATE AUG 20 '59 | |
| | | 24b. REGISTRAR'S SIGNATURE <u>John S. Kline</u> | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8793

CERTIFICATE OF DEATH

18757

Reg. Dist. No.

| | | | | | | | | | |
|---|--|--|---|--|---|--|---|------------------------------|-----------------------------|
| 1. PLACE OF DEATH a. COUNTY <i>BALTO.</i> | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i> | | b. COUNTY <i>Baltimore</i> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Colgate</i> | | c. LENGTH OF STAY IN lb <i>short</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Colgate</i> | | d. STREET ADDRESS <i>7940 Eastern Ave. (24)</i> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>7940 Eastern Ave. (24)</i> | | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <i>THOMAS</i> | | First | Middle | Last | 4. DATE OF DEATH <i>COOPER</i> | Month | Day | Year | |
| 5. SEX <i>MALE</i> | | 6. COLOR OR RACE <i>WHITE</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH <i>MAY 9, 1885</i> | 9. AGE (In years last birthday) <i>74 yrs.</i> | 10. IF UNDER 1 YEAR Months | 11. IF UNDER 24 HRS Days | 12. IF UNDER 24 HRS Hours | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <i>Showman (Artist)</i> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>Omaha, Neb.</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i> | | | |
| 13. FATHER'S NAME <i>Samson Cooper</i> | | 14. MOTHER'S MAIDEN NAME <i>Mary Stell</i> | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address <i>Mr. Pat. Cooper 7940 Eastern Ave (24)</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>1977x</i> | | DUE TO <i>Chronic heart disease</i> | | INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. | | (b) <i>Carcinoma of Prostate</i> | | | | | | | |
| (c) | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Hour a. m. p. m. | | Month 19 | Day | Year | 20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) <i>Patterson</i> | (County) <i>Paterson</i> | (State) <i>N. Jersey</i> |
| 21. I certify that I attended the deceased from alive on <i>8-24-59</i> , 19 <i>59</i> , to <i>8-24-59</i> , 19 <i>59</i> , that I last saw the deceased | | | | | | | | | |
| and that death occurred at <i>John G. Connally 418 Eastern Blvd.</i> M.D. | | | | | | | | | |
| | | | | | | ADDRESS (Street, city or town, state) <i>Patterson N. Jersey</i> | | | |
| | | | | | | DATE SIGNED <i>8-24-59</i> | | | |
| 22e. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i> | | 22f. DATE THEREOF <i>8-24-59</i> | | 22g. NAME OF CEMETERY OR CREMATORIAL <i>Laurel Grove</i> | | 22h. LOCATION (City, town, or county) <i>Patterson</i> | | (State) <i>N. Jersey</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>John G. Connally</i> | | ADDRESS <i>418 Eastern Blvd.</i> | | 24a. REC'D BY REGISTRAR DATE <i>AUG 26 '59</i> | | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Klaus</i> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
Page 3 should be detached for use as the burial/transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8794. CERTIFICATE OF DEATH

118758

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|--|---------------------------|--|-----------------------------------|
| 1. PLACE OF DEATH o COUNTY BALTIMORE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institut on- Residence before admission) o STATE MARYLAND b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD | | c. LENGTH OF STAY IN lb 3 DAYS | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE | |
| d. STREET ADDRESS 2004 EDGENWOOD STREET | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) WALTER | | 4. DATE OF DEATH First Middle Last Month Day Year COPE Jr AUGUST 1 1959 | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH MARCH 31 1918 |
| 9. AGE (In years last birthday) yrs. 11 | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RADIO OFFICER | | 10b. KIND OF BUSINESS OR INDUSTRY MERCHANT MARINE | |
| 11. BIRTHPLACE (State or foreign country) GREENSBORO, NO. CAROLINA | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME WALTER B COPE | | 14. MOTHER'S MAIDEN NAME HELEN TYLER | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN <input type="checkbox"/> | | 16. SOCIAL SECURITY NO. 231-05-9531 | |
| 17. INFORMANT CLIN REC VET ADM HOSP FT HOWARD MARYLAND | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LIVER FAILURE | | INTERVAL BETWEEN ONSET AND DEATH UNKNOWN | |
| DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) PORTAL CIRRHOsis | | UNKNOWN | |
| DUE TO (c) ALCOHOLISM | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from July 29, 1959, to AUGUST 1, 1959, and that death occurred at 5:00 AM, from the causes and on the date stated above | | | |
| ACTUAL SIGNATURE CHARLES ALLEN | | ADDRESS (Street, city or town, state) VAH Fort Howard Maryland DATE SIGNED 8-1-59 | |
| PHYSICIAN'S NAME (Type) CHARLES ALLEN M.D. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 8-4-59 | |
| 22c. NAME OF CEMETERY OR CREMATORIUM BALTIMORE NATIONAL | | 22d. LOCATION (City, town, or county) BALTIMORE MARYLAND (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Marion P. Armacost Funeral Home | | 24a. REG'D BY REGISTRAR Aug 3 1959 DATE | |
| 4600 Liberty Heights Ave Baltimore Md | | 24b. REGISTRAR'S SIGNATURE Charles S. Moore | |



TO DEPUTY M.E.: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

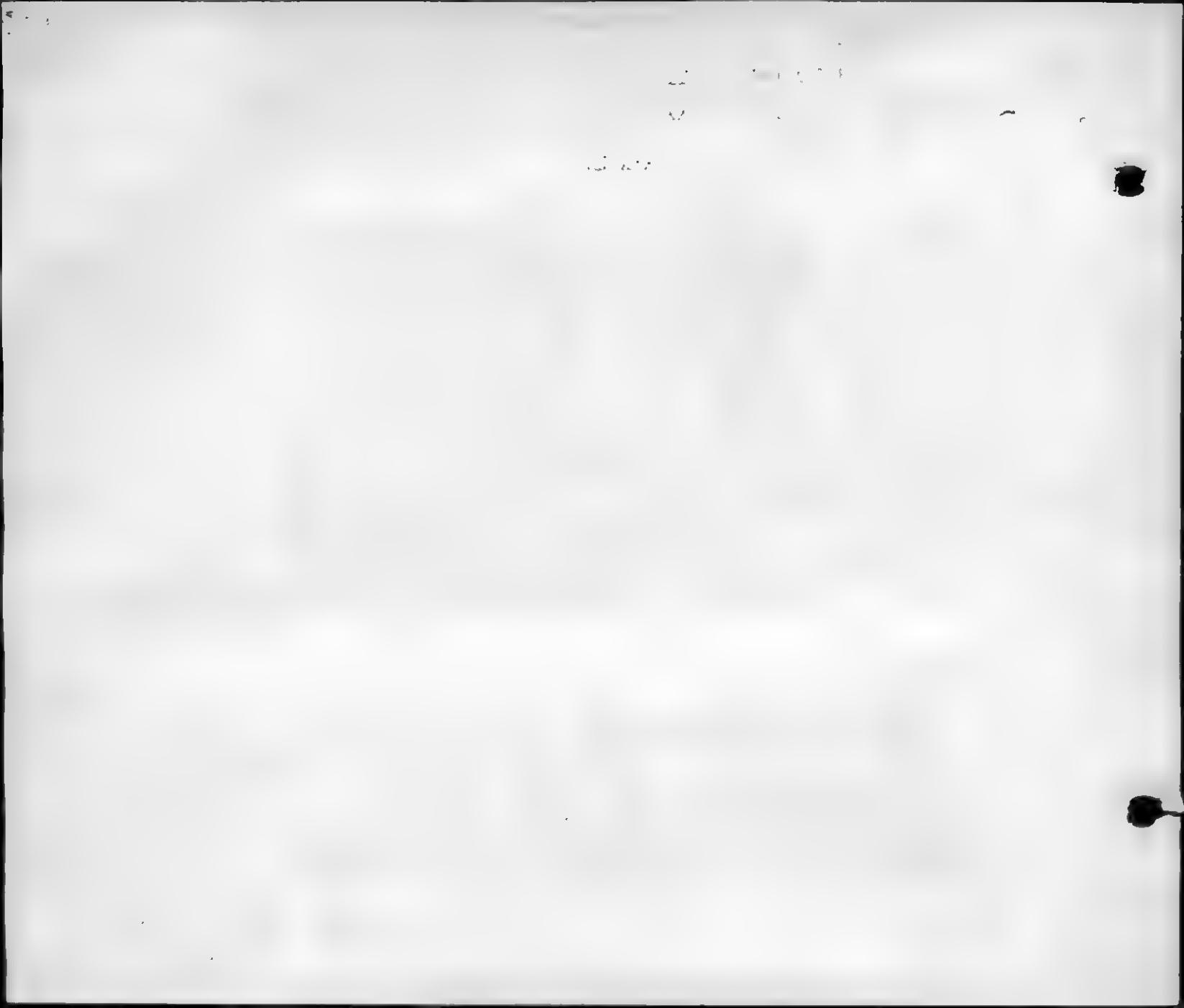
FOR STATE
HEALTH DEPT.

1 X 1
8795 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 08759

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) | |
| Baltimore Talbot Maryland | | a. STATE Maryland COUNTY Talbot | |
| b. CITY OR TOWN (If out side corporate limits, write RURAL and give nearest town) | | c. LENGTH OF STAY IN TB life | |
| WHITE MARSH | | d. CITY OR TOWN (If out side corporate limits, write RURAL and give nearest town) | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | d. STREET ADDRESS | |
| Cawenton Ave. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | | Last 4. DATE OF DEATH | |
| Clifton Christopher Cummings | | Month | |
| Middle | | Day | |
| 5. SEX Male | | Year | |
| 6. COLOR OR RACE White | | 5. DATE OF BIRTH | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | May 27 1870 | |
| 10a. USUAL OCCUPATION (Type kind of work done during most of working life, even if retired) | | 9. AGE (in years last birthday) | |
| Carpenter | | 49 | |
| 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Larry Co. | | Maryland | |
| 13. FATHER'S NAME s. unknown | | 12. CITIZEN OF WHAT COUNTRY? | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no, or unknown) | | 14. MOTHER'S MAIDEN NAME | |
| No | | Unknown | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| 216-12-6485 | | Sister in Law. Cawenton Ave | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | Address | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | INTERVAL BETWEEN ONSET AND DEATH | |
| 433.0 | | Adam's Stokes Syndrome | |
| DUE TO | | Sudden | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | arteriosclerosis of age. | |
| DUE TO | | | |
| (b) | | | |
| (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Hour o. m. p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 19 | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| FRANK T. KASIK JR | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | |
| Burial | | Aug 14, 1959 | |
| 22c. NAME OF CEMETERY OR CREMATORIAL | | 22d. LOCATION (City, town, or county) (State) | |
| Rebirth Cemetery | | Rebirth Md | |
| 23. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | |
| S. Garrison | | St Michaels | |
| 24a. REC'D BY REGISTRAR | | 24b. REGISTRAR'S SIGNATURE | |
| AUG 17 '59 | | C. L. Thomas | |



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
5M 9/55

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8796 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08760

Reg. Dist. No.

| | | | |
|--|---------------------------|---|-------------------------------|
| 1. PLACE OF DEATH a. COUNTY Baltimore Co. | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Towson | | c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6835 Blenheim Rd. | | d. STREET ADDRESS 6835 Blenheim Rd. | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) Benjamin | | First G. | Middle Davis |
| 4. DATE OF DEATH Aug. 31 1959 | | Last | Month Day Year |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 2-14-1904 |
| 9. AGE (in years last birthday) 55 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) cashier | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Benjamin G. Davis, Sr. | | 14. MOTHER'S MAIDEN NAME Emma R. Miller | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. 213-05-6816 17. INFORMANT Mrs Hughlo J. Davis same | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO | | Cerebral thrombosis Arteriosclerosis, generalized 1-2 mos. 10 yrs. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pulmonary embolus | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> ACTUAL SIGNATURE <i>Benjamin J. Van Pelt</i> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <i>Benjamin J. Van Pelt</i> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <i>8/31/59</i> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 9-3-59 | |
| 22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Pine Grove | | 22d. LOCATION (City, town, or county) Baltimore County (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck 5305 Harford Rd. | | 24a. REC'D BY REGISTRAR DATE SEP 4 '59 | |
| | | 24b. REGISTRAR'S SIGNATURE <i>Charles S. Heath</i> | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8797

CERTIFICATE OF DEATH

Reg. Dist. No.

08761

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY BALTO. | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND | | b. COUNTY BALTO. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTO. | | c. LENGTH OF STAY IN 1b LIFE | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTO. | | d. STREET ADDRESS 9225 BELAIR RD. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9225 BELAIR RD. | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |

| | | | | | | | |
|---|---------------------|-------------------|----------------------|---|------------------|----------------|---------------------|
| 3. NAME OF DECEASED (Type or print) | First IDA | Middle | Last DAVIS | 4. DATE OF DEATH AUG. 7 | Month | Day | Year 1959 |
|---|---------------------|-------------------|----------------------|---|------------------|----------------|---------------------|

| | | | | | | | | |
|-------------------------|----------------------------------|---|--------------------------------------|---|--------------------------------------|------------------------------------|------------------|----------------|
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH 2-29-1876 | 9. AGE (in years last birthday) 83 yrs | IF UNDER 1 YEAR Months | IF UNDER 24 HRS Days | Hours | Min |
| | | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | |

| | | | |
|---|--|---|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | 10b. KIND OF BUSINESS OR INDUSTRY HOME | 11. BIRTHPLACE (State or foreign country) BALTO., MD. | 12. CITIZEN OF WHAT COUNTRY U.S.A. |
|---|--|---|--|

| | |
|--|---|
| 13. FATHER'S NAME JOHN YOUNG | 14. MOTHER'S MAIDEN NAME MARGARET VANSANT |
|--|---|

| | | | |
|--|--|--|-----------------------------------|
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | 16. SOCIAL SECURITY NO. NONE | 17. INFORMANT MRS. S. W. BAUMILLER | Address 9225 BELAIR RD. |
|--|--|--|-----------------------------------|

| | |
|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | INTERVAL BETWEEN ONSET AND DEATH 3-4 days. |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Artery Thrombosis | |
| 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Cerebral Artery Thrombosis | |
| DUE TO (c) Generalized Advanced Atherosclerotic Cardiovascular Disease, (card.) | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |

| | | |
|---|---|--|
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) |

| |
|--|
| 21. I certify that I attended the deceased from Aug. 19, 1958, to 7 Aug. 1958, that I last saw the deceased alive on 6 Aug. 1959, and that death occurred at 3:15 P.M. from the causes and on the date stated above. |
|--|

| | | | |
|---|------|--|---------------------------------|
| ACTUAL SIGNATURE John C. Hyde | M.D. | ADDRESS (Street, city or town, state) 7527 Belair Rd. Baltimore F-9-53 | DATE SIGNED 8-11-1959 |
| PHYSICIAN'S NAME (Type) John C. Hyde | | | |

| | | | |
|--|---------------------------------------|---|---|
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 22b. DATE THEREOF 8-11-1959 | 22c. NAME OF CEMETERY OR CREMATORIAL LORRAINE PARK CEM. | 22d. LOCATION (City, town, or county) BALTO., MD. |
|--|---------------------------------------|---|---|

| | | | |
|---|-----------------------------------|--|--|
| 23. FUNERAL DIRECTOR'S SIGNATURE Josephine Funeral Home | ADDRESS 7701 Belair Rd. | 24a. REC'D BY REGISTRAR DATE AUG 11 '59 | 24b. REGISTRAR'S SIGNATURE Cynthia S. Krause |
|---|-----------------------------------|--|--|



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

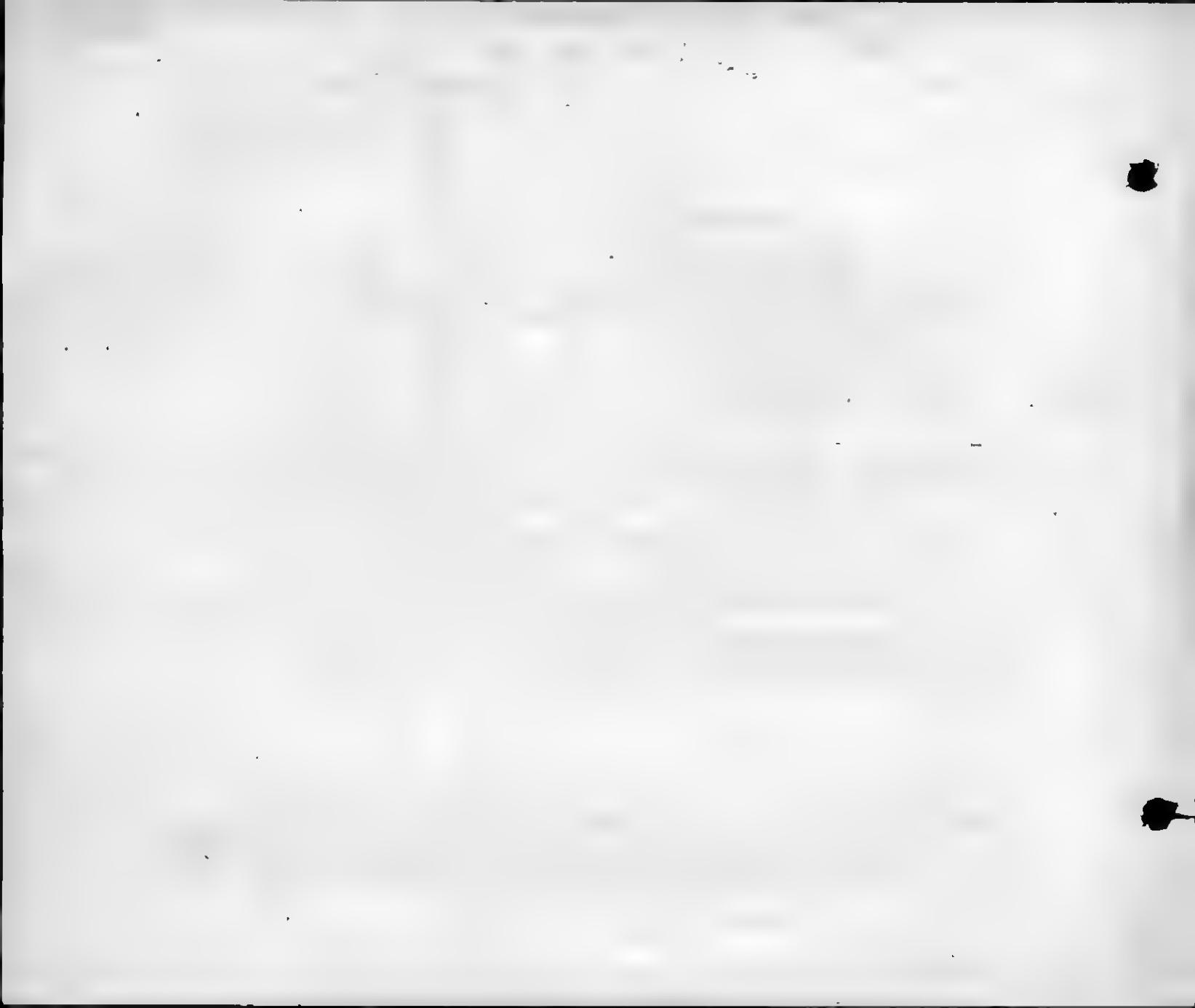
8763

CERTIFICATE OF DEATH

08762

Reg. Dist. No.

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY 1119 Plover Drive | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) b. STATE Md. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halethorpe | | c. LENGTH OF STAY IN 1b Life | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus | |
| 3. NAME OF DECEASED (Type or print) Lillian | | 4. STREET ADDRESS 5117 Lees Ave. | |
| 5. SEX Female | | 6. COLOR OR RACE White | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Aug. 17, 1886 | |
| 9. AGE (In years last birthday) 73 yrs. | | 10. IF UNDER 1 YEAR Months 01 Days 21 Hours 00 Min. 00 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Virginia | | 12. CITIZEN OF WHAT COUNTRY U.S. A. | |
| 13. FATHER'S NAME Nelson T. Warren | | 14. MOTHER'S MAIDEN NAME Elizabeth Tyler | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Tel. no. or unknown) # | | 16. SOCIAL SECURITY NO - - - - - | |
| 17. INFORMANT Ruth Fraley | | Address 1119 Plover Drive | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 155.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last: (b) DUE TO Malignant + Rehydratory (c) DUE TO Carcinoma of Gall Bladder. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Metastases. | | | |
| INTERVAL BETWEEN ONSET AND DEATH | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour o. m. p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>June</u> , 1958, to <u>28 Aug</u> , 1959, that I last saw the deceased alive on <u>28 Aug</u> , 1959, and that death occurred at <u>5:00 P.M.</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>William J. Bryson</i> | | ADDRESS (Street, city or town, state) <i>605 E. Diamondback</i> | |
| PHYSICIAN'S NAME (Type) <i>William J. Bryson</i> | | DATE SIGNED <i>30 Aug 59</i> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 8/31/59 | |
| 22c. NAME OF CEMETERY OR CREMATORIAL Loudon Park Cem. | | 22d. LOCATION (City, town, or county) Belts. Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph J. Ambrose Jr.</i> | | 24a. REC'D BY REGISTRAR DATE AUG 31 '59 | |
| ADDRESS <i>1328 Shipley St. 100</i> | | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i> | |

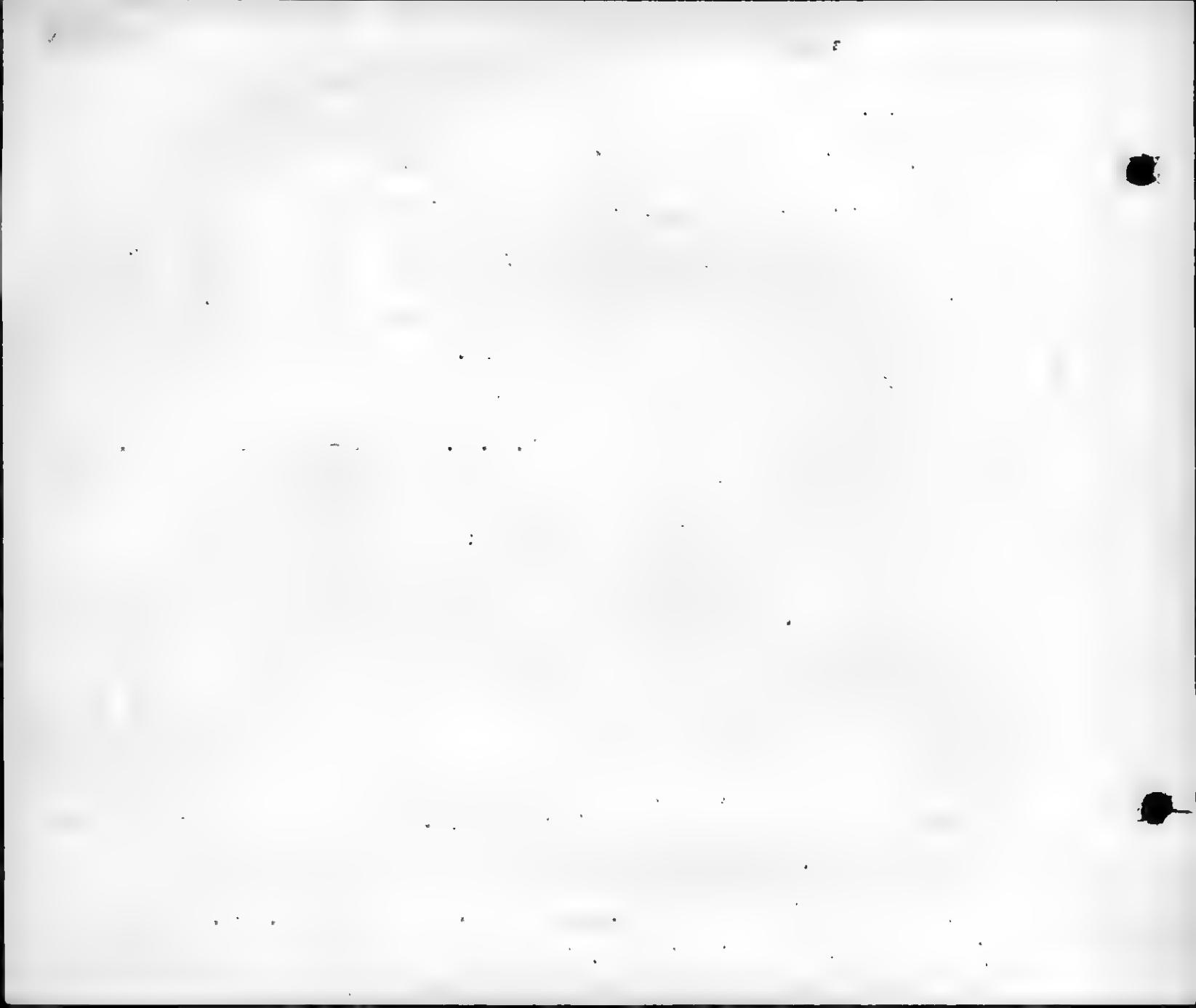


HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 Item 3, Film 3-47 9/1/59.cac
 8798 **CERTIFICATE OF DEATH** 08763

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Maryland</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Owings Mills</i> | | c. LENGTH OF STAY IN 1b <i>16 hours</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Rosewood State Training School</i> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <i>Volker</i> | | First <i>Maximilian</i> | Middle <i>de Groot</i> |
| 4. DATE OF DEATH <i>8 22 1959</i> | | Month <i>8</i> | Day <i>22</i> |
| 5. SEX <i>Male</i> | | 6. COLOR OR RACE <i>white</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <i>6/16/59</i> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <i>Md.</i> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME <i>Volker M. de Groot</i> | | 14. MOTHER'S MAIDEN NAME <i>Mary Adams</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> | | 16. SOCIAL SECURITY NO. <i>Mr. V. M. de Groot - 1225 Winston Ave.</i> | |
| 17. INFORMANT <i>Mr. V. M. de Groot - 1225 Winston Ave.</i> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Aspiration of stomach content</i> | | INTERVAL BETWEEN ONSET AND DEATH | |
| DUE TO <i>+ 2</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>large interatrio-ventricular</i> (b) <i>defect of heart</i> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Mongolism</i> | | 19. WAS AN AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour o. m. p. m. <i>19</i> | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 7:35 PM, from the causes and on the date stated above. ACTUAL SIGNATURE <i>Peter W. Rieckert</i> ADDRESS (Street, city or town, state) <i>4307 Mainfield Ave., Baltimore, Md.</i> DATE SIGNED <i>14, 1959</i> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 22b. DATE THEREOF <i>8/25/59</i> | |
| 22c. NAME OF CEMETERY OR CREMATORIAL <i>Baltimore National Cem.</i> | | 22d. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Peter W. Rieckert & Sons - Baltimore</i> | | 24a. REGISTRATION DATE <i>AUG 25 1959</i> | |
| ADDRESS <i>2044 263 XV5</i> | | 24b. REGISTRAR'S SIGNATURE C. L. T. <i>C. L. T. 25 1959</i> | |



TO HOSPITAL OR SENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death: Page 4
 may be retained by the hospital or attending physician.

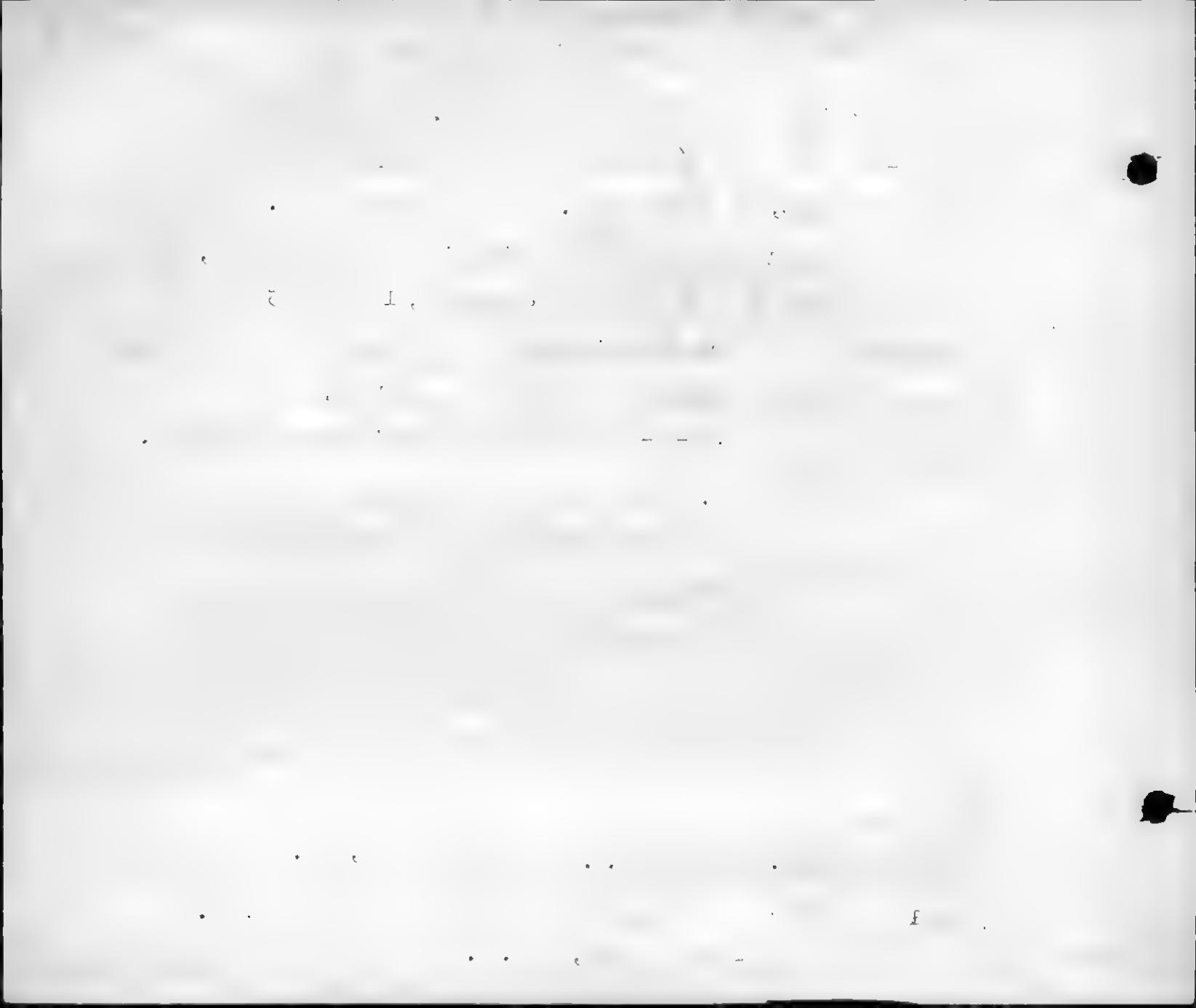
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8799 CERTIFICATE OF DEATH 08764

Reg. Dist. No.

| | | | | | | |
|---|---------------------------|---|--------------------------------------|--|------------------------------------|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Md. b. COUNTY | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | c. LENGTH OF STAY IN 1b 16 weeks | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Summit Nursing Home, 98 Smithwood Ave. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | | | | |
| 3. NAME OF DECEASED (Type or print) Mary | | d. STREET ADDRESS 2817 Waldorf Ave. | | | | |
| 4. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH January 20, 1884 | 9. AGE (In years last birthday) 75 yrs | 10. IF UNDER 1 YEAR Months Days | 11. IF UNDER 24 HRS Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress | | 10b. KIND OF BUSINESS OR INDUSTRY Mens Tailoring Shop | | 11. BIRTHPLACE (State or foreign country) Italy | | 12. CITIZEN OF WHAT COUNTRY? Italy |
| 13. FATHER'S NAME Salvatore Arena | | 14. MOTHER'S MAIDEN NAME Unknown | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. 215-01-8709 | | 17. INFORMANT Miss Lee DiBlasi, Marriottsville Rd. | | Address |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | Aspiration Pneumonia | | INTERVAL BETWEEN ONSET AND DEATH 7 days | | |
| DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) | | Parkinsons Disease | | > 1 yr | | |
| DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (c) | | Cerebral Arteriosclerosis | | 7 1/2 yr | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) (d) Diabetes Mellitus | | (e) A.S.H.D.C Corp Ht Failure | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from 2-17-1959, to 8-1-1959, that I last saw the deceased alive on 8-1-1959, and that death occurred at 1:30 P.M., from the causes and on the date stated above. ACTUAL SIGNATURE George M. Ramapuram, M.D. | | | | ADDRESS (Street, city or town, state) 7501 Marston Road, Baltimore 7, Md. | | |
| DATE SIGNED 8/8/59 | | | | | | |
| PHYSICIAN'S NAME (Type) George M. Ramapuram, M.D. | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 8/10/59 | | 22c. NAME OF CEMETERY OR CREMATORIAL Holy Redeemer Cemetery | | 22d. LOCATION (City, town, or county) Baltimore, Md. (State) |
| 23. FUNERAL DIRECTOR'S SIGNATURE L. Vernon & Son | | ADDRESS 4611 Park Heights, Balto. Md. | | 24a. REC'D BY REGISTRAR DATE | | 24b. REGISTRAR'S SIGNATURE Clinton J. Thomas |
| | | | | | | AUG 10 '59 |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8800

CERTIFICATE OF DEATH

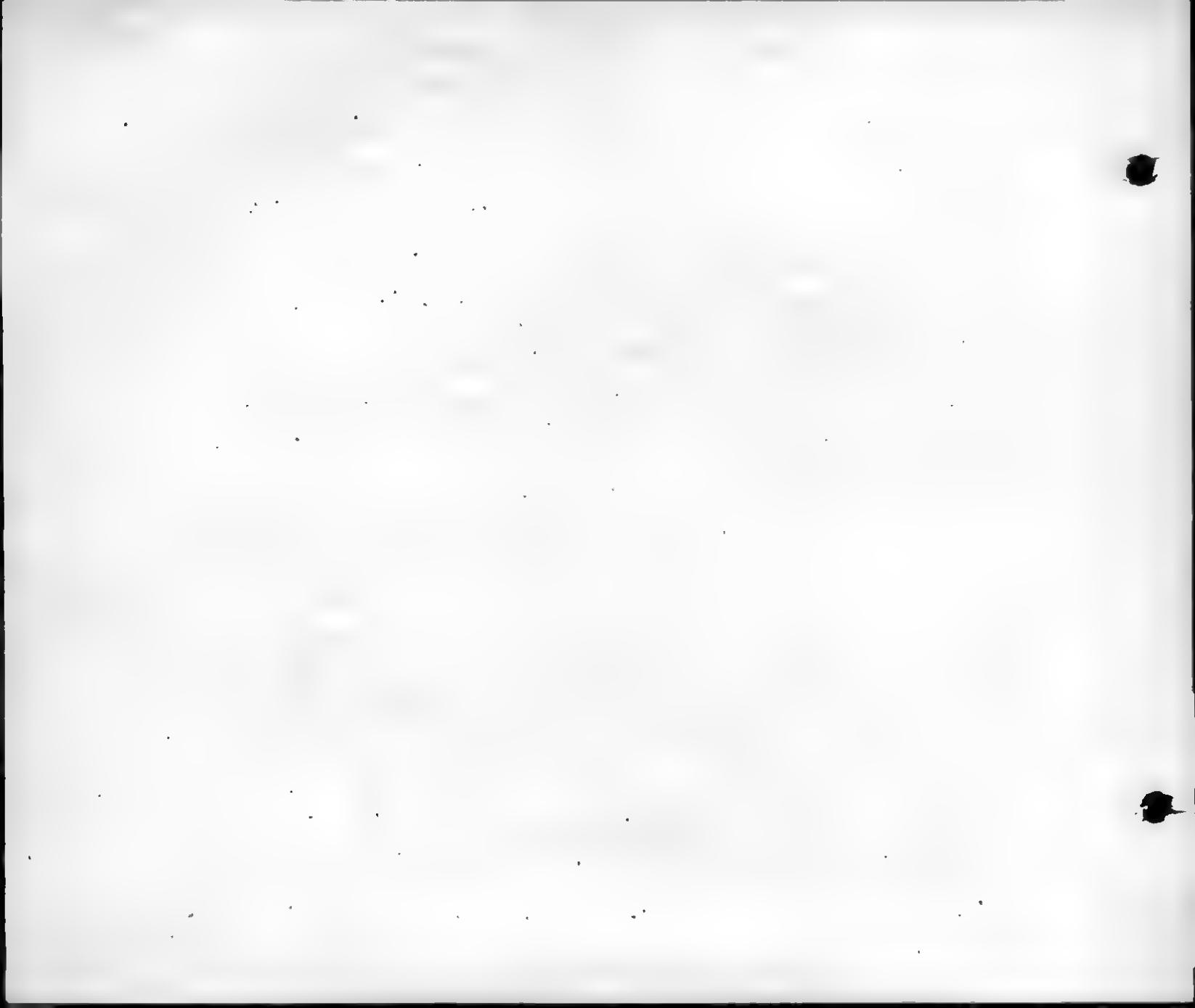
08765

Reg. Dist. No.

TO HOSPITAL OR ENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | | | |
|---|----------------------------------|---|--|--|---|--|--|-----------------------------|------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MARYLAND</u> | | b. COUNTY <u>WICOMICO</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OWINGS HILLS</u> | | c. LENGTH OF STAY IN 1b <u>53 years</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u> | | d. STREET ADDRESS <u>312 SMITH STREET</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ROSEWOOD STATE TRAINING SCHOOL</u> | | | | d. STREET ADDRESS | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>NELLIE</u> | | First <u>T</u> | Middle <u></u> | Last <u>DISHARON</u> | 4. DATE OF DEATH <u>AUGUST 16 1959</u> | Month <u>AUGUST</u> | Day <u>16</u> | Year <u>1959</u> | |
| 5. SEX <u>FEMALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>8/16/892</u> | 9. AGE (In years last birthday) <u>68 yrs</u> | 10. IF UNDER 1 YEAR Months <u></u> | 11. IF UNDER 24 HRS Days <u></u> | 12. Hours <u></u> | 13. Minutes <u></u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NEVER WORK</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>NEVER WORK</u> | | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>AMERICAN</u> | | | |
| 13. FATHER'S NAME <u>MARCELLUS T. DISHARON</u> | | 14. MOTHER'S MAIDEN NAME <u>ELLEN HAYMAN</u> | | INFORMANT <u>Rosewood Records</u> | | Address | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? <input type="checkbox"/> (Yes, no or unknown) <input type="checkbox"/> (If yes, give war or dates of service) | | | | | | | | | |
| 16. SOCIAL SECURITY NO. <u>—</u> | | | | | | | | | |
| 17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Y Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) DUE TO (b) DUE TO (c) | | | | | | | | | |
| 18. INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | | | | | |
| 20c. TIME OF INJURY Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) <u>Salisbury</u> | | (County) <u>Maryland</u> | (State) <u>MD</u> |
| 21. I certify that I attended the deceased from <u>19</u> , 19 <u>59</u> , to <u>19</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>19</u> , and that death occurred at <u>4:30 PM</u> , from the causes and on the date stated above. | | | | | | | | | |
| ACTUAL SIGNATURE <u>Peter W. Rieckert</u> | | ADDRESS (Street, city or town, state) <u>4307 Marfield Ave</u> | | | | | | | |
| PHYSICIAN'S NAME (Type) <u>Peter W. Rieckert</u> | | DATE SIGNED <u>8-17-59</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>8/18/59</u> | | 22c. NAME OF CEMETERY OR CREMATORIAL <u>Parsons Cemetery</u> | | 22d. LOCATION (City, town, or county) <u>Salisbury, Maryland</u> | | (State) <u>MD</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Hill & Johnson Co. Salisbury, Md.</u> | | ADDRESS <u>Norman & Baker</u> | | 24a. REC'D BY REGISTRAR <u>AUG 21 1959</u> | | 24b. REGISTRAR'S SIGNATURE <u>Curry B. Moore</u> | | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8801 CERTIFICATE OF DEATH

08766

Reg. Dist. No.

TO HOSPITAL OR ENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE | | c. LENGTH OF STAY IN 1b 14 months | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION (House in the Pines) | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cottage City Md. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION (House in the Pines) | | f. STREET ADDRESS 3713 41st avenue, | |
| 3. NAME OF DECEASED (Type or print) MARY | | First C. | Middle Donley |
| 4. DATE OF DEATH August 16, 1959 | | Month Month | Day Day |
| 5. SEX FEMALE | | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> |
| 8. WIDOWED <input type="checkbox"/> | | 9. DIVORCED <input type="checkbox"/> | 10. DATE OF BIRTH Sept 8, 1890 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY own home | |
| 11. BIRTHPLACE (State or foreign country) Louisiana. | | 12. CITIZEN OF WHAT COUNTRY? U S A | |
| 13. FATHER'S NAME Dominick Latapie | | 14. MOTHER'S MAIDEN NAME Cattie Wagner | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. INFORMANT Raleigh A. Donley | |
| 17. ADDRESS | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage | |
| DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. | | INTERVAL BETWEEN ONSET AND DEATH 12 days | |
| (b) Generalized arteriosclerosis | | DUE TO INTERVAL BETWEEN ONSET AND DEATH 10 yrs. | |
| (c) _____ | | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour o. m. _____ p. m. _____ | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 6209 Frederick Ave. | | 20f. (City or town) (County) Baltimore (State) Md. | |
| 21. I certify that I attended the deceased from 4-7-1958 to 8-16-1959 , that I last saw the deceased alive on 8-15-1959 , and that death occurred at 12:30 P.M. from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) Baltimore 28, Md. | |
| ACTUAL SIGNATURE Wilmor K. Gallagher | | DATE SIGNED 8-17-59 | |
| PHYSICIAN'S NAME (Type) Wilmor K. Gallagher | | M.D. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Aug 20, 1959 | |
| 22c. NAME OF CEMETERY OR CREMATORIAL Elmwood Cemetery | | 22d. LOCATION (City, town, or county) West Virginia | |
| 23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons | | ADDRESS Hyattsville, Md. | |
| 24a. REC'D BY REGISTRAR C. L. Tamm | | 24b. REGISTRAR'S SIGNATURE C. L. Tamm | |
| DATE AUG 21 '59 | | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8802

CERTIFICATE OF DEATH

Reg. Dist. No.

88767

| | | | | | | | | |
|---|---------------------------|---|--|---|---|--|-----------|------------|
| 1. PLACE OF DEATH a. COUNTY Baltimore | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland | | b. COUNTY | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9122 Liberty Road | | d. STREET ADDRESS 9122 Liberty Road | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) FRANK | | First | Middle F. | Last DUNN | 4. DATE OF DEATH August | Month 4 | Doy 19 | Year 59 |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH April 16, 1870 | 9. AGE (in years last birthday) 89 | 10. IF UNDER 1 YEAR Months | 11. IF UNDER 24 HRS Days | 12. Hours | 13. Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired farmer | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? | | |
| 13. FATHER'S NAME ? Dunn | | | 14. MOTHER'S MAIDEN NAME ? Kirk | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) None | | | 16. SOCIAL SECURITY NO None | | | 17. INFORMANT Mrs. Ernest E. Greenwalt-9122 Liberty Road | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work <input checked="" type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) Randallstown | | (County) | (State) |
| 21. I certify that I attended the deceased from <u>July 30, 1957</u> , to <u>Aug 4, 1957</u> , that I last saw the deceased alive on <u>July 30, 1957</u> , and that death occurred at <u>7:41 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>8627 Liberty Rd.</u> DATE SIGNED <u>July 30, 1957</u> | | | | | | | | |
| ACTUAL SIGNATURE <u>J. P. J. Ellin</u> | | M.D. | | | | | | |
| PHYSICIAN'S NAME (Type) <u>J. P. J. Ellin</u> | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 8/6/59 | 22c. NAME OF CEMETERY OR CREMATORIUM Mt. Olive Cemetery | | 22d. LOCATION (City, town, or county) Randallstown, Maryland | | | (State) |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Ellin</u> | | ADDRESS <u>8627 Liberty Rd.</u> | | 24a. REC'D BY REGISTRAR FMS 5 '59 | | 24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kline</u> | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
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 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08768

8803

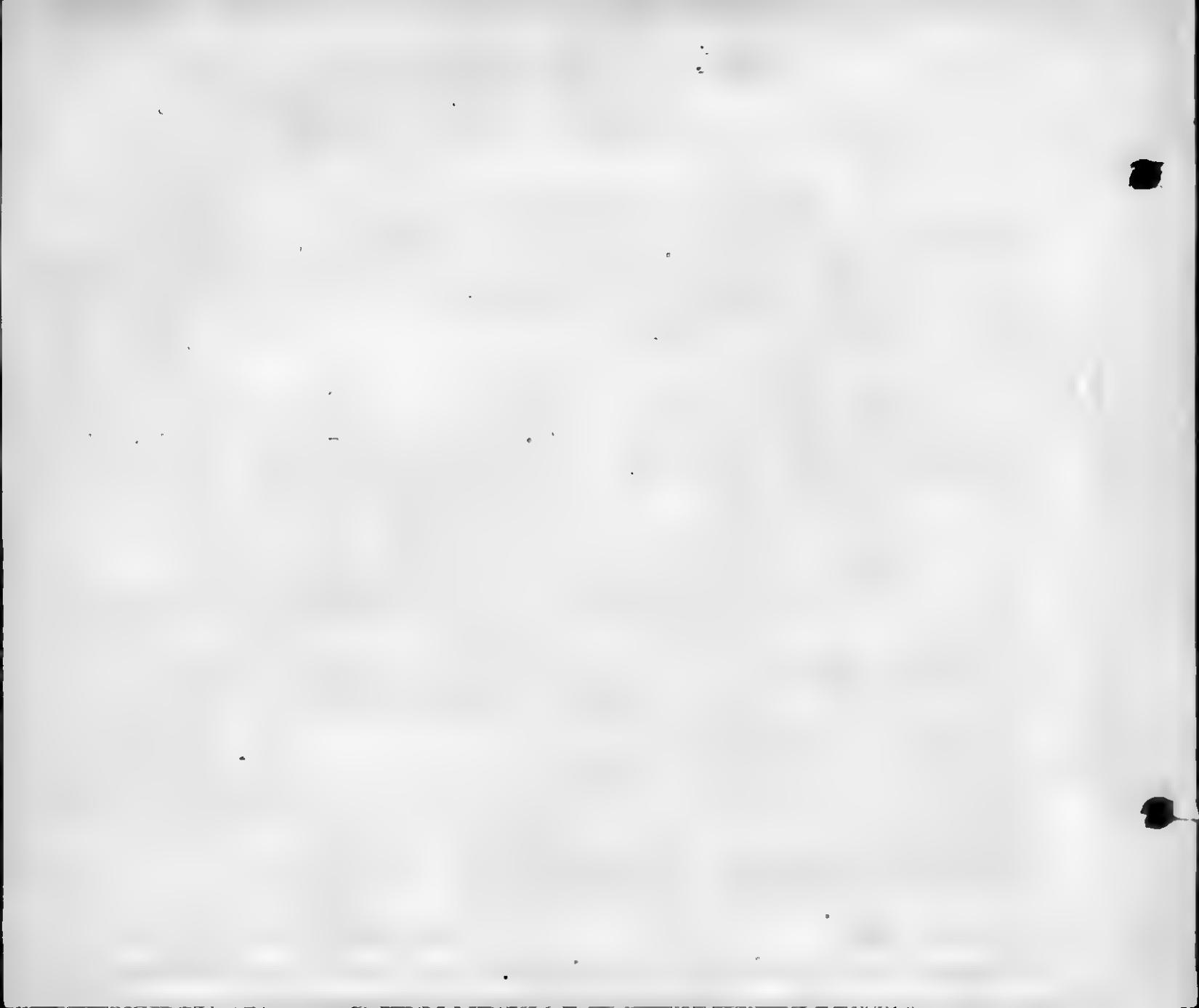
CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | |
|---|--|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 55 Towson | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 514 Club Lane | | d. STREET ADDRESS 514 Club Lane | | | |
| e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) MINA R. DUPRE | | 4. DATE OF DEATH Month August 11 Year 1959 | | | |
| 5. SEX Female 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> August 6, 1883 | 9. AGE (In years lost, birthday) 76 yrs | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY None | 11. BIRTHPLACE (State or foreign country) Canada | 12. CITIZEN OF WHAT COUNTRY Canada | |
| 13. FATHER'S NAME Alphonse Racine | | 14. MOTHER'S MAIDEN NAME Mary Jane Ross | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? No | | 16. SOCIAL SECURITY NO. None | 17. INFORMANT Mrs. Andree Moore-514 Club Lane, Towson 4 | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | INTERVAL BETWEEN ONSET AND DEATH 1959 | | | |
| 19.00 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) (c) | | DUE TO Cystadenoma Fallopian 13 yrs arthritis | | | |
| 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21. I certify that I attended the deceased from <u>Aug 1</u> , 1959, to <u>Aug 11</u> , 1959, that I last saw the deceased alive on <u>Aug 4</u> , 1959, and that death occurred at <u>7:30 AM</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>4-11-59</u> M.D. <u>Littlermble, Md.</u> DATE SIGNED <u>5/11/59</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 22b. DATE THEREOF Aug. 11, 1959 | 22c. NAME OF CEMETERY OR CREMATORIUM Cote Des Neiges | 22d. LOCATION (City, town, or county) Montreal, Canada | (State) |
| 23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Towson, Inc. 1050 York Rd. Towson Md. | | 24a. REC'D BY REGISTRAR DATE AUG 13 '59 | 24b. REGISTRAR'S SIGNATURE Arthur S. Trahan | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
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1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
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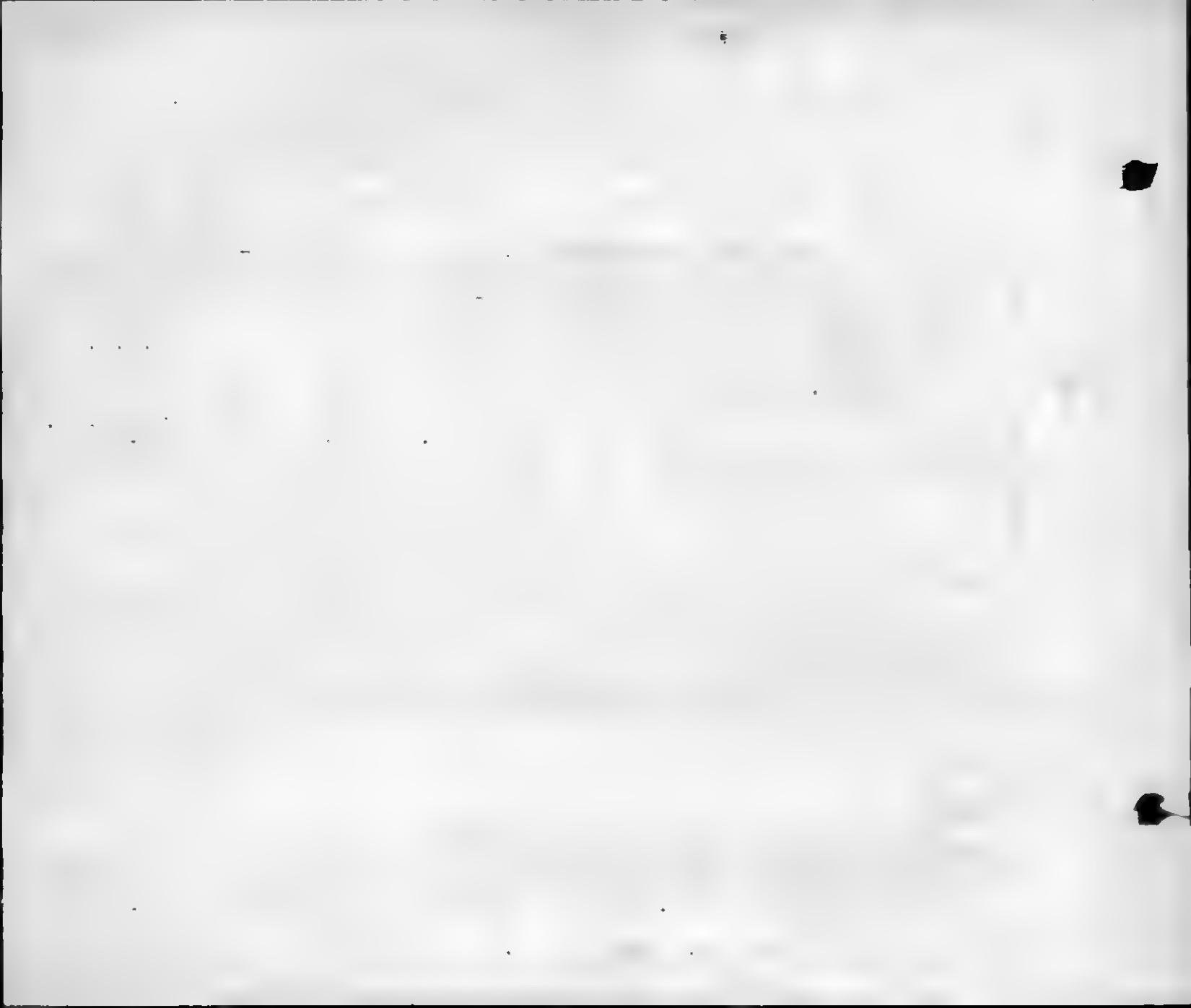
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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18
8804 CERTIFICATE OF DEATH

08769

Reg. Dist. No.

| | | | | | | | |
|--|---------------------------|--|-------------------------------|---|------------------------------------|---|-----------------------------------|
| 1. PLACE OF DEATH a. COUNTY Baltimore | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived) [institution, Residence before admission] a. STATE Maryland | | b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson | | c. LENGTH OF STAY IN 1b 5 months | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Cockeysville | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Towson Convalescent Home | | d. STREET ADDRESS Church Lane | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) | First Mary | Middle Elizabeth | Last Ensor | 4. DATE OF DEATH 8-1-59 | Month 8 | Day 1 | Year 59 |
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 3-13-1874 | 9. AGE (In years last birthday) 85 yrs | 10. IF UNDER 1 YEAR Months 0 | 11. IF UNDER 24 HRS Days 0 | 12. IF UNDER 24 HRS Hours 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | 10b. KIND OF BUSINESS OR INDUSTRY home | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Edward A. Sparks | | 14. MOTHER'S MAIDEN NAME Elizabeth Ann Sparks | | Address Towson 4, Md. | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <input type="checkbox"/> no | | 16. SOCIAL SECURITY NO. none | | 17. INFORMANT Lawrence E. Ensor, Campbell Bldg. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Percarditis</u> 434.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) DUE TO (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) 1927 York Rd, Timonium, Md. | |
| 21. I certify that I attended the deceased from <u>December, 1958</u> , to <u>July</u> , 1959, that I last saw the deceased alive on <u>July 21, 1959</u> , and that death occurred at <u>7 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. DATE SIGNED ACTUAL SIGNATURE <u>M. X. Quinn</u> ADDRESS <u>1927 York Rd, Timonium, Md.</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 8-3-59 | | 22c. NAME OF CEMETERY OR CREMATORIUM St. Joseph's Catholic | | 22d. LOCATION (City, town or county) (State) Cockeysville, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Brooks Funeral Service, Towson 4, Md. | | ADDRESS | | 24a. REC'D BY REGISTRAR AUG 5 '59 | | 24b. REGISTRAR'S SIGNATURE Charles S. Klaus | |
| VS A15 (4) ISM 9/55 | | | | | | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08770

8805

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|--|--|--|---|--|--|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Baltimore | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md | | b. COUNTY Arundel | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Almonville | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverside Beach | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Paradise Nursing Home | | | | d. STREET ADDRESS 416 Correl Street Rd | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Elizabeth | | First | Middle | 4. DATE OF DEATH ERNEST | Month Aug | Day 16 | Year 1959 |
| 5. SEX F | | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Aug 1 1900 | 9. AGE (In years at birthday) 81 | 10. UNDER 1 YEAR Months Years | 11. IF UNDER 24 HRS. Hours Min |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Md. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME Machris Polyzai | | 14. MOTHER'S MAIDEN NAME Machris Bidoftka | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Family. Jones | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | INTERVAL BETWEEN ONSET AND DEATH 2 weeks | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 171X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. | | DUE TO (b) DUE TO (c) | | Mucous carcinos of cervis advanced. Poor | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Hour a. m. p. m. | | Month 19 | Day | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) Baltimore | (County) (State) |
| 21. I certify that I attended the deceased from: Aug 14, 1959, to Aug 16, 1959, that I last saw the deceased alive on Aug 14, 1959, and that death occurred at 142 M, from the causes and on the date stated above. | | | | | | ADDRESS (Street, city or town, state) | |
| ACTUAL SIGNATURE FREDERICK H. ZERZVYRD M.D. | | | | | | DATE SIGNED | |
| PHYSICIAN'S NAME (Type) FREDERICK H. ZERZVYRD | | 22c. NAME OF CEMETERY OR CREMATORI Holy Cross | | 22d. LOCATION (City, town, or county) Baltimore | | (State) | |
| 22a. BURIAL / CREMATION, DATE THEREOF REMOVAL (Specify) 8-20-59 | | 22b. DATE THEREOF | | 22d. LOCATION (City, town, or county) Baltimore | | (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE McAuley Funeral Home | | ADDRESS 130 S. 16th St. | | 24a. REC'D BY REGISTRAR DATE AUG 18 '59 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kline | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death:
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8805 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 7 FilmG248 9-17-59 et

105771

Reg. Dist. No.

TO DEPUTY ATTORNEY: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Page 1 and 2 with the registrar prior to burial, cremation, or removal.

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bradford | | c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route 7 and Raffel Road | | d. STREET ADDRESS Spring and Pratt Sts. | |
| 3. NAME OF DECEASED (Type or print) ROSE | | First ROSE | Middle EVANS |
| 4. DATE OF DEATH August 21 1959 | | 5. SEX Female | 6. COLOR OR RACE Colored |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH 9. AGE (In years last birthday) 49 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done) 10b. KIND OF BUSINESS OR INDUSTRY during most of working life, even if retired) Labour | | 11. BIRTHPLACE (State or foreign country) Armenia N.C. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Freel Johnson | |
| 14. MOTHER'S MAIDEN NAME Penreatta Blount | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease | | | |
| DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour a. m. p. m. | Month, Day, Year 19 | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <i>Charles S. Petty</i> | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED 8/22/59 |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 9-21-59 | 22c. NAME OF CEMETERY OR CREMATORIUM mt Calvary Cemetery | 22d. LOCATION (City, town, or county) Brooklyn MD 21236 (State) |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Elmer C. Wilson</i> | ADDRESS 1000 Broadway | 24e. REC'D BY REGISTRAR DATE SEP 8 '59 | 24f. REGISTRAR'S SIGNATURE Arthur & Kraus |



TO HOSPITAL OR PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8807

CERTIFICATE OF DEATH

08772

Reg. Dist. No.

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catoonsville | | c. LENGTH OF STAY IN 1b 26yr9mth19dys | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | First John | Middle G. | Last Favour |
| 4. DATE OF DEATH | Month August | Day 18 | Year 19 59 |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Aug. 31, 1885 |
| 9. AGE (In years lost, birthday) 73 yrs. | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer | 10b. KIND OF BUSINESS OR INDUSTRY Dairy | 11. BIRTHPLACE (State or foreign country) Maryland |
| 12. CITIZEN OF WHAT COUNTRY? U. S. A. | 13. FATHER'S NAME Joseph G. Favour | | |
| 14. MOTHER'S MAIDEN NAME Jennie Standiford | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown | | |
| 16. SOCIAL SECURITY NO. Unknown | 17. INFORMANT Records: SPRING GROVE STATE HOSPITAL | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Cerebral vascular accident INTERVAL BETWEEN ONSET AND DEATH | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Arteriosclerotic cardiovascular disease | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER) | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from Aug. 13, 19 59, to Aug. 18, 19 59, that I last saw the deceased alive on Aug. 18, 19 59, and that death occurred at 9:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Stella Wachsler MD SPRING GROVE STATE HOSPITAL 8-18-59 | | | |
| PHYSICIAN'S NAME (Type) Stella Wachsler, M. D. | Catoonsville 28, Maryland | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 22b. DATE THEREOF 8-20-59 | 22c. NAME OF CEMETERY OR CREMATORIUM Woodlawn Cemetery | 22d. LOCATION (City, town, or county) (State) Woodlawn, Md |
| 23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul Street | ADDRESS | 24a. REC'D BY REGISTRAR AUG 20 '59 DATE | 24b. REGISTRAR'S SIGNATURE Arthur S. Haas |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8808 CERTIFICATE OF DEATH

08773

Reg. Dist. No.

TO HOSPITAL OR ENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

| | | | | | |
|---|--|---|---|---|----------------------------|
| 1. PLACE OF DEATH a. COUNTY BALTO | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MD. | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 18 LOCUST DRIVE | | d. STREET ADDRESS 18 LOCUST DRIVE | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) | First ANASTASIA | Middle H. | Last FIELDS | | |
| 4. DATE OF DEATH | Month AUG | Day 20 | Year 1959 | | |
| 5. SEX F | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH MAY 19, 1874 | | |
| 9. AGE (In years last birthday) 85 | 10. IF UNDER 1 YEAR Months 0 | 11. IF UNDER 24 HRS Days 0 | 12. IF UNDER 24 HRS Hours 0 | | |
| 13. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEKEEPER | 10b. KIND OF BUSINESS OR INDUSTRY HOME | 11. BIRTHPLACE (State or foreign country) N. Y. | 12. CITIZEN OF WHAT COUNTRY | | |
| 14. FATHER'S NAME DAVID HAGGERTY | 14. MOTHER'S MAIDEN NAME JOHANNA O'KEEFE | Address | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) no | 16. SOCIAL SECURITY NO — | 17. INFORMANT Miss VIRGINIA FIELDS-18 LOCUST DRIVE | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | | | |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | |
| <i>Degenerative, C.V. Disease</i> | | | INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i> | | |
| <i>Generalized Arterio Sclerosis</i> | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER) | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Month, Doy, Year Hour o. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Catonsville | 20f. (City or town) BALTO. | (County) Md. | (State) Md. |
| 21. I certify that I attended the deceased from Aug 1, 1959 to Aug 20, 1959 that I last saw the deceased alive on Aug 20, 1959 , and that death occurred at 11 P.M. from the causes and on the date stated above. | | | | | |
| ACTUAL SIGNATURE <i>Jacques S. Howell</i> | | | | ADDRESS (Street, city or town, state) Catonsville | DATE SIGNED 8-22 |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 8-24-59 | 22c. NAME OF CEMETERY OR CREMATORIAL London Park Cem. | 22d. LOCATION (City, town, or county) BALTO. | (State) Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Farley Funeral Home-Catonsville, Md.</i> | | ADDRESS | 24a. REC'D BY REGISTRAR AUG 25 '59 | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i> | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8809

CERTIFICATE OF DEATH

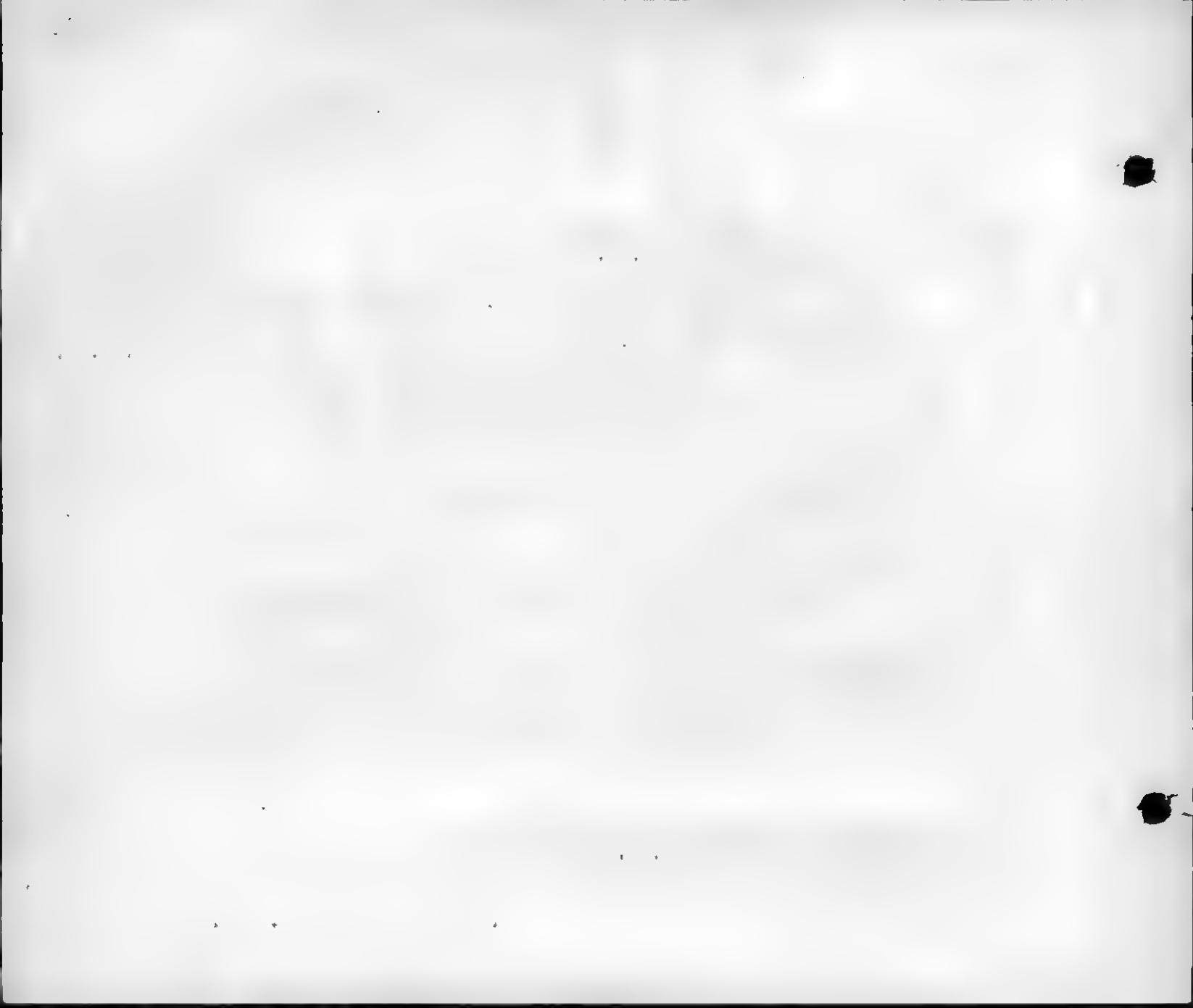
Reg. Dist. No.

08774

| | | | |
|---|---------------------------|---|-----------------------------------|
| 1. PLACE OF DEATH o COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o STATE Maryland b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | c. LENGTH OF STAY IN 1b 13 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Frederick Middle E. W. Last Foops | | 4. DATE OF DEATH Month August Day 31 Year 1959 | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Dec. 17, 1883 |
| 9. AGE (In years to last birthday) 75 yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) candy maker (rtd) | | 10b. KIND OF BUSINESS OR INDUSTRY Confectioner | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY U. S. A. | |
| 13. FATHER'S NAME Unknown | | 14. MOTHER'S MAIDEN NAME Unknown Mary Heinz | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown | | 16. SOCIAL SECURITY NO. Unknown | |
| 17. INFORMANT Records: SPRING GROVE STATE H.S. ITAL | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] | | | |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Bronchopneumonia 10 days | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Cerebral Vascular Accident 5 wks | | | |
| DUE TO Generalized Arteriosclerosis Undetermined | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| Diabetes Mellitus | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>August 30, 1959</u> to <u>August 31, 1959</u> , that I last saw the deceased alive on <u>August 30, 1959</u> , and that death occurred at <u>7:20 AM</u> , from the causes and on the date stated above ACTUAL SIGNATURE <u>Edward T. Schnoor, M.D.</u> ADDRESS (Street, city or town state) <u>3718 Delvere Rd. Baltimore, Md.</u> DATE SIGNED <u>8-31-59</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 9/3/59 | |
| 22c. NAME OF CEMETERY OR CREMATORIUM Loudon Park Cem. | | 22d. LOCATION (City, town, or county) Balto., Md. (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Siekner & Son - Balt. Md.</u> | | 24a. REC'D BY REGISTRAR DATE SEP 1 '59 | |
| | | 24b. REGISTRAR'S SIGNATURE <u>Edward T. Schnoor, M.D.</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 1 and 2 should be filed in by the attending physician or attending physician and completely filled in by the attending physician. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

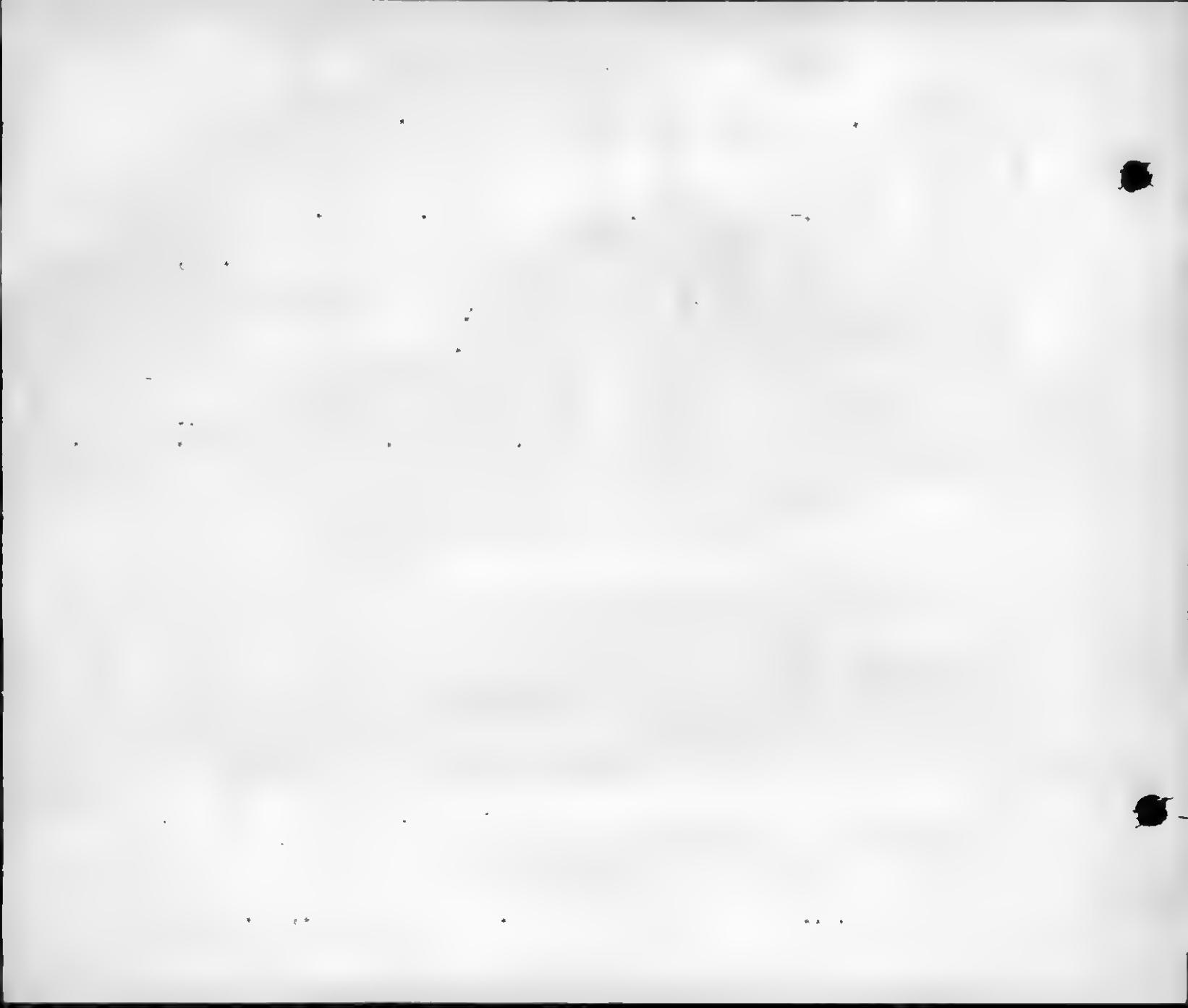
08775

8810

CERTIFICATE OF DEATH

Reg. Dist. No.

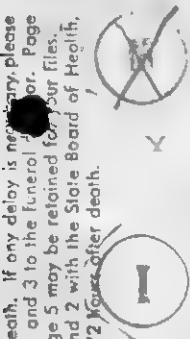
| | | | | | | | | | |
|---|---------------------------|---|--|--|--|--|---------------------|--------------|---------|
| 1. PLACE OF DEATH a. COUNTY Balto. | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. | | b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | | d. STREET ADDRESS 308 E. 26th St. | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Fried Nursing Ho.-133 Slade Ave. | | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) | | First PHOEBE | Middle FRANKLIN | Last | 4. DATE OF DEATH Aug. 21, 1959 | Month 19 | Day 21 | Year 1959 | |
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 13, 1883 | | 9. AGE (In years last birthday) 76 yrs. | 10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY at home | | 11. BIRTHPLACE (State or foreign country) Md. | | 12. CITIZEN OF WHAT COUNTRY? | | | |
| 13. FATHER'S NAME Willard Green | | 14. MOTHER'S MAIDEN NAME Sophia Robinson | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Miss Dorothy L. Franklin - 308 E. 26th St. | | Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X | | Cerebral Hemorrhage | | | | INTERVAL BETWEEN ONSET AND DEATH 3 days | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause (b), DUE TO | | Cardio-vascular Disease | | | | 3 years | | | |
| DUE TO | | (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | | | | | |
| 20c. TIME OF INJURY Hour a. m. p. m. | | Month 19 | Day | Year | 20d. INJURY OCCURRED While at work <input type="checkbox"/> or work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) |
| 21. I certify that I attended the deceased from <u>Aug. 1</u> , 1959, to <u>Aug. 21</u> , 1959, that I last saw the deceased alive on <u>Aug. 21</u> , 1959, and that death occurred at <u>6:30 PM</u> , from the causes and on the date stated above. ACTUAL SIGNATURE <u>Harry Glassman</u> M.D. <u>712 W. Lafayette St.</u> PHYSICIAN'S NAME (Type) <u>HARRY GLASSMAN</u> | | ADDRESS (Street, city or town, state) DATE SIGNED | | | | | | | |
| 22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial | | 22b. DATE THEREOF 8.24.59 | 22c. NAME OF CEMETERY OR CREMATORIAL Loudon Park Cem. | | 22d. LOCATION (City, town, or county) Balto., Md. | | | (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Schickel & Sons - Balto. 17</u> | | ADDRESS | | 24a. REC'D BY REGISTRAR DATE AUG 25 '59 | | 24b. REGISTRAR'S SIGNATURE <u>Calvin S. Krause</u> | | | |



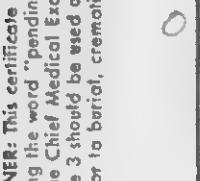
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.



VS. A15ME
5M 2/37



MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8811 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08776

Reg. Dist. No.

Item 8 File G248 9-8-59 et

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Balto. | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY Catonsville | |
| b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Catonsville | | c. LENGTH OF STAY IN lb | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2226 Powers Lane | | e. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Catonsville | |
| f. STREET ADDRESS 2226 Powers Ln | | g. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Rose Ann Frederick | | 4. DATE OF DEATH Aug. 23 1959 | Month Day Year |
| 5. SEX F | | 6. COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH 1896 Dec. 3, 1897 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress Ret | | 10b. KIND OF BUSINESS OR INDUSTRY Restaurant | |
| 11. BIRTHPLACE (State or foreign country) Md. | | 12. CITIZEN OF WHAT COUNTRY? Anh. Fwrd. | |
| 13. FATHER'S NAME --- Fowler | | 14. MOTHER'S MAIDEN NAME Anh. Fwrd. | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 17. INFORMANT Henry Frederick 2226 Powers Ln | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH Coronary thrombosis | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) GEO. S. M. KEEFER M.D. | | DATE SIGNED Aug. 29. 59 | |
| 22e. BURIAL, CREMATION, OR REMOVAL (Specify) Burial 8-30-59 | | 22c. NAME OF CEMETERY OR CREMATORIAL Cathedral Cem. | |
| 22d. LOCATION (City, town, or county) Balto. Md. | | (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Farley Funeral Home Catonsville, Md. | | 24a. REC'D BY REGISTRAR DATE SEP 2 '59 | |
| | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8812

CERTIFICATE OF DEATH

Reg. Dist. No.

118777

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY BALTIMORE | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - WOODLAWN | | c. LENGTH OF STAY IN 1b 40 YEARS | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6608 TALLULAH AVE | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - WOODLAWN | |
| f. STREET ADDRESS 6608 TALLULAH AVE | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) CHARLES GALLMEYER | | 4. DATE OF DEATH 1959 | |
| 5. SEX M | | 6. COLOR OR RACE W | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH SEPT. 24, 1882 | |
| WIDOWED <input type="checkbox"/> | | DIVORCED <input type="checkbox"/> | |
| 9. AGE (In years last birthday) 76 yrs. | | 10. IF UNDER 1 YEAR Months: 0 Days: 0 Hours: 0 Min: 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER | | 10b. KIND OF BUSINESS OR INDUSTRY FARMER | |
| 11. BIRTHPLACE (State or foreign country) VIRGINIA | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME NOT KNOWN | | 14. MOTHER'S MAIDEN NAME NOT KNOWN | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) NO | | 16. SOCIAL SECURITY NO. NONE | |
| 17. INFORMANT WIFE MRS GRACE GALLMEYER | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GENERALIZED CARCINOMATOSIS DUE TO PROBABLE ORIGIN - STOMACH. INTERVAL BETWEEN ONSET AND DEATH 5 MONTHS. | |
| Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause, if any. (b) DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) BALTIMORE (State) MARYLAND | |
| 21. I certify that I attended the deceased from JUNE 12, 1952 to AUGUST 13, 1959 , that I last saw the deceased alive on AUGUST 11, 1959 , and that death occurred at 4:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) EDWIN L. PIERPONT, M.D. DATE SIGNED 8/13/59 | | | |
| ACTUAL SIGNATURE Edwin L. Pierpont | | PHYSICIAN'S NAME (Type) EDWIN L. PIERPONT, M.D. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 8/17/59 | |
| 22c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill | | 22d. LOCATION (City, town, or county) (State) AAcc. Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE John T. Stansbury | | ADDRESS 6411 Windsor Mill Rd. | |
| 24a. REC'D BY REGISTRAR DATE AUG 18 '59 | | 24b. REGISTRAR'S SIGNATURE Charles S. Kline | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-trunk permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Farm PHM3. Page 5 may be retained for files.

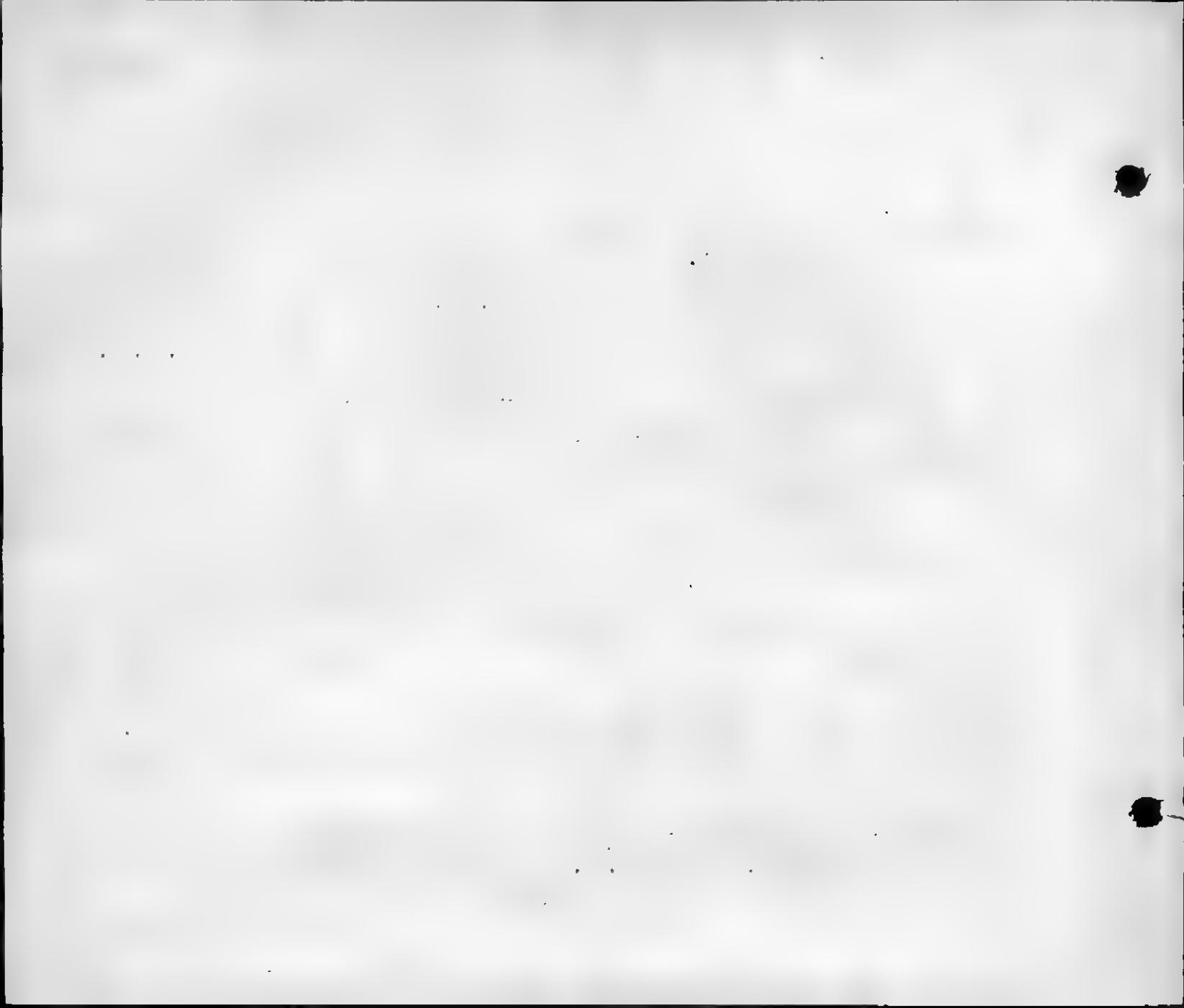
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. 08778

8813

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | c. LENGTH OF STAY IN lb 2mth18days | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL | | | |
| 3. NAME OF DECEASED (Type or print) Caroline Carrie T. Carrie Gardner | | First | Middle |
| 4. SEX female | | 5. COLOR OR RACE white | 6. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 7. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 8. DATE OF BIRTH Nov. 23, 1872 | | 9. AGE (In years last birthday) 86 yrs | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) saleslady | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Augustus G Gardner | | 14. MOTHER'S MAIDEN NAME Ann Rebecca Airhardt | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? Unknown No | | 16. SOCIAL SECURITY NO. 17. INFORMANT HICKIEWIX No Records: SPRING GROVE STATE HOSPITAL Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 904.7 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO due to cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) possible fall accident | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury, part of body, etc.) No history of fall found in bed with injured hip X Ray showed fracture | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. — p. m. July 17 1959 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital |
| 20f. (City or town) Catonsville, Md. | | (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) GEO. S. M. KIEFFER George M. Kieffer, M. D. | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | |
| 22. BURIAL, CREMATION, OR REMOVAL (Specify) Bur 9 ap | | 22b. DATE THEREOF 8/3/59 | |
| 22c. NAME OF CEMETERY, OR CREMATORIAL Loudon Park Cemetery | | 22d. LOCATION (City, town, or county) Baltimore, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE George S. Kieffer | | 24a. REC'D BY REGISTRAR DATE AUG 3 '59 | |
| ADDRESS 1117 18th St. Baltimore, Md. | | 24b. REGISTRAR'S SIGNATURE George S. Kieffer | |



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISM
5M 2/57

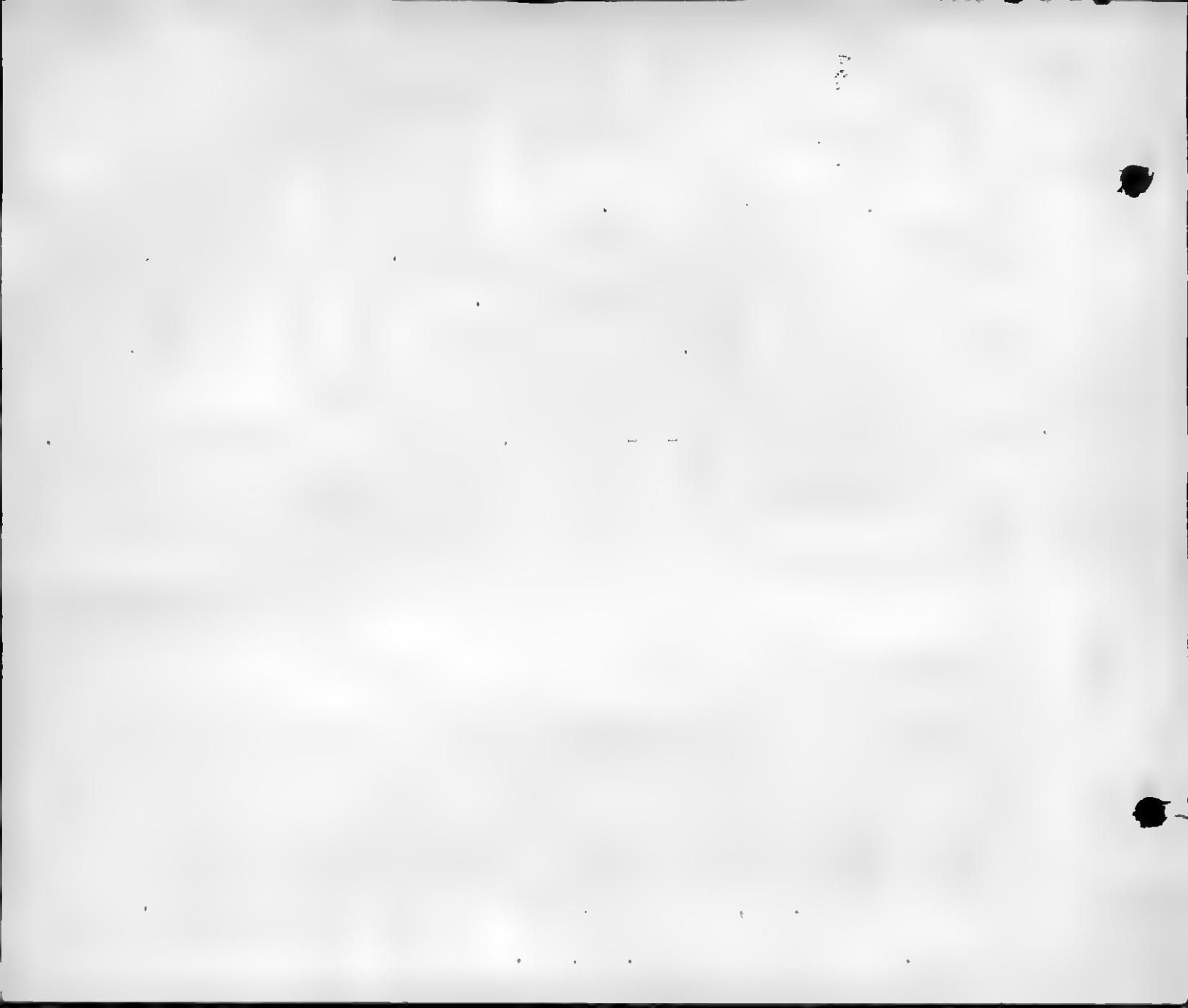
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8757 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08779

Reg. Dist. No.

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk | | c. LENGTH OF STAY IN TB 7 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Residence, 211 Cleveland Ave. | | d. STREET ADDRESS 53 Dundalk 211 Cleveland Avenue | |
| e. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) | First Steve | Middle Gaydos | Last Sr. |
| 4. DATE OF DEATH | Month August | Day 9, | Year 1959 |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Sept. 1, 1892 |
| 9. AGE (in years months) 66 yrs. | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coal Miner | 10b. KIND OF BUSINESS OR INDUSTRY Pa. Mines | 11. BIRTHPLACE (State or foreign country) Hungary |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | 13. FATHER'S NAME Unknown | | |
| 14. MOTHER'S MAIDEN NAME Unknown | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) No | |
| 16. SOCIAL SECURITY NO 193-07-7213 | | 17. INFORMANT Mrs. Teresa Gaydos 211 Cleveland Ave. | |
| 18. CAUSE OF DEATH [Enter only one cause per line, or (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 44 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO A-s-c-u DISEASE | | Address INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) KNE | |
| 20c. TIME OF INJURY Hour o m p. m 19 | 20d. INJURY OCCURRED at work <input type="checkbox"/> Not at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) M. B. DAVIS M.D. | M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED 8/11/59 |
| 22a. BURIAL, CREMATION (Remove if specify) Burial | 22b. DATE THEREOF Aug. 13, 59 | 22c. NAME OF CEMETERY OR CREMATORIUM Sacred Heart of Jesus | 22d. LOCATION (City, town, or county) German Hill Rd. Md. (State) |
| 23. FUNERAL DIRECTOR'S SIGNATURE John J. Duda 7922 Wise Ave. 22, Md. | ADDRESS | 24a. REC'D BY REGISTRAR DATE AUG 12 '59 | 24b. REGISTRAR'S SIGNATURE Curtis S. Thorne |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

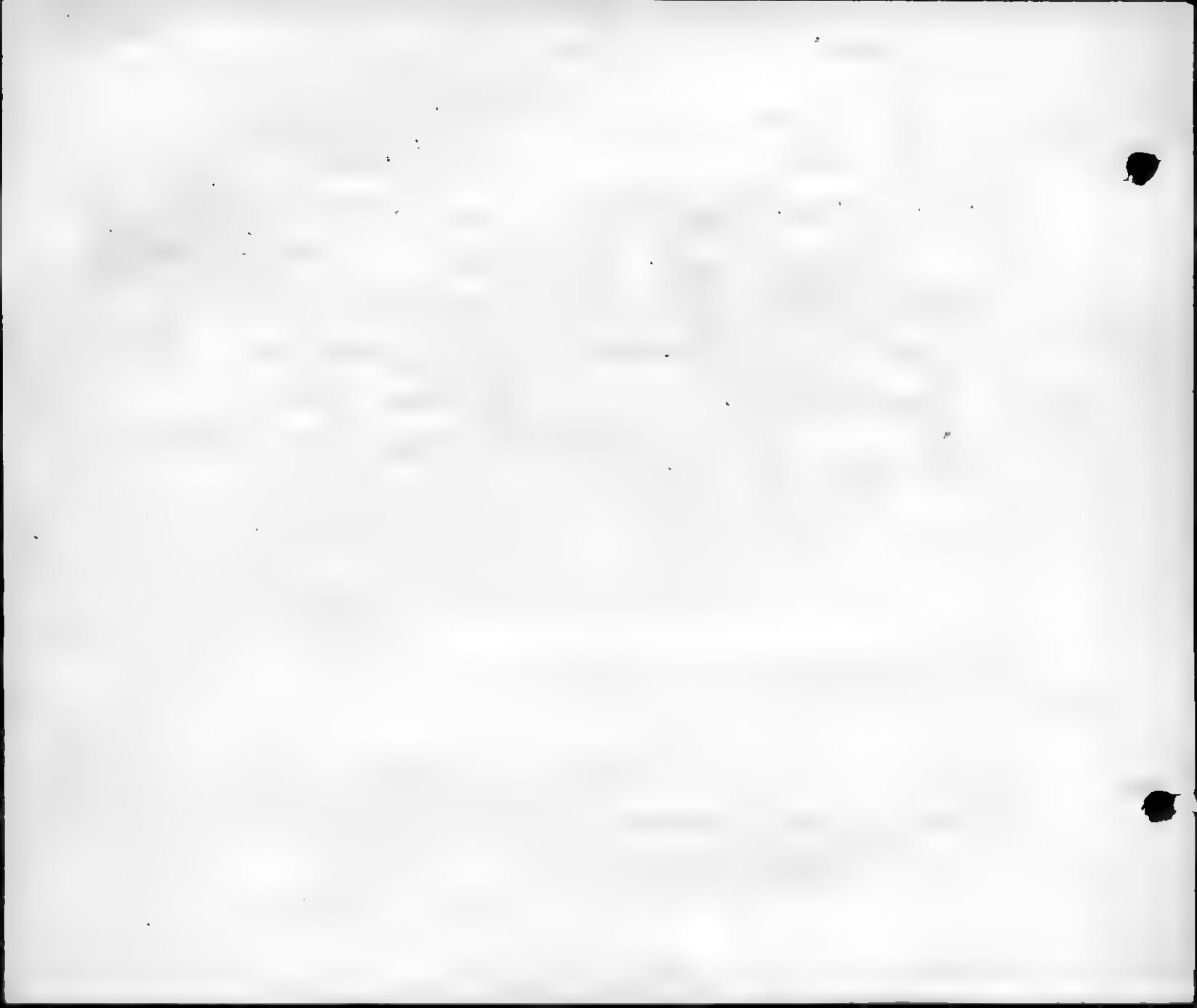
08780

8814

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived - If institution: Residence before admission) a. STATE | |
| Baltimore Maryland | | b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. LENGTH OF STAY IN 1b | |
| Garrison | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | |
| Foxleigh Nursing Home | | Baltimore | |
| 3. NAME OF DECEASED (Type or print) | | First | Middle |
| Mignon | | 2. | Genora |
| 4. DATE OF DEATH | | Aug 17, 1959 | |
| 5. SEX | | 6. COLOR OR RACE | |
| Female | | White | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH | |
| WIDOWED <input type="checkbox"/> | | 9. AGE (In years last birthday) yrs. | |
| DIVORCED <input type="checkbox"/> | | 43 | IF UNDER 1 YEAR Months Days Hours Min |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| Housewife | | at Home | |
| 11. PLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| Baltimore, Md | | USA | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | |
| Joseph Taylor | | Gladie Kann | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or other) No | | 16. SOCIAL SECURITY NO | |
| 17. INFORMANT | | Address | |
| 26-01-3549 David Genora - 4214 Shoreland | | age | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | Metastatic Carcinoma | |
| DUE TO | | Carcinoma of the breast | |
| Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) | | 3 years | |
| DUE TO | | | |
| (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION STATED IN PART I (o) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from _____, 1950 to present, 19____, that I last saw the deceased alive on _____, 1959, and that death occurred at 8:45 AM, from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) | |
| ACTUAL SIGNATURE | | DATE SIGNED | |
| BERNARD BURGER M.D. 6721 Leisterstown Rd. Balt. 5, Md. 8/1/59 | | | |
| PHYSICIAN'S NAME (Type) | | BERNARD BURGER | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | |
| Burial Aug 3, 1959 | | 22c. NAME OF CEMETERY OR CREMATORIAL | |
| 22d. LOCATION (City, town, or county) (State) | | Chizuk Amuno Baltimore, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE | | 24a. REC'D BY REGISTRAR DATE AUG 6 '59 | |
| Sol Levenson & Sons - 1124-26 7th North Ave | | 24b. REGISTRAR'S SIGNATURE Gallion S. Evans | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8815

Item 1 FilmG247 8-27-59 et

08781

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY

Baltimore

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Pikesville

c. LENGTH OF STAY IN 1b

25 yrs.

d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION

At home - 100 Clarendon Ave.

3. NAME OF
DECEASED
(Type or print)

Nancy

First

Middle

Last

4. DATE
OF
DEATH

August 16,

1959

Month

Day

Year

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

Oct. 23, 1885

9. AGE (In years
lost birthday)

73

10. IF UNDER 1 YEAR

yrs.

11. IF UNDER 24 HRS

Months Days Hours Min

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

own home

11. BIRTHPLACE (State or foreign country)

Wilmington, Del.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Author Brown

14. MOTHER'S MAIDEN NAME

Crawford C Richmond

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)
(If yes, give war or dates of service)

No

None

16. SOCIAL SECURITY NO.

INFORMANT

Address

Pikesville 8, Md.
Mr. Thomas E. Goode, 100 Clarendon Ave.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)44-1
DUE TOConditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.

(b)

DUE TO

(c)

cerebral vascular accident, rt hemi-
3 wife

Hypertensive cardiovascular disease 10 years

INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19
p. m.20d. INJURY OCCURRED
While at work Not while at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from June 1953 to 16 Aug. 1959 that I last saw the deceased
alive on 14 Aug. 1959, and that death occurred at 7 A.M. from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATURE

Paul H. Royse

M.D.

808 Reisterstown Rd. 16 Aug. 1959

PHYSICIAN'S
NAME (Type)

PAUL H. Royse

Pikesville 8, Md.

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

22b. DATE THEREOF

Aug. 18, 1959

22c. NAME OF CEMETERY OR CREMATORI

Druid Ridge Cemetery

22d. LOCATION (City, town, or county)

Pikesville 8, Maryland

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

Frank H. Neill - Pikesville, Md.

ADDRESS

24a. REC'D BY REGISTRAR

AUG 21 1959

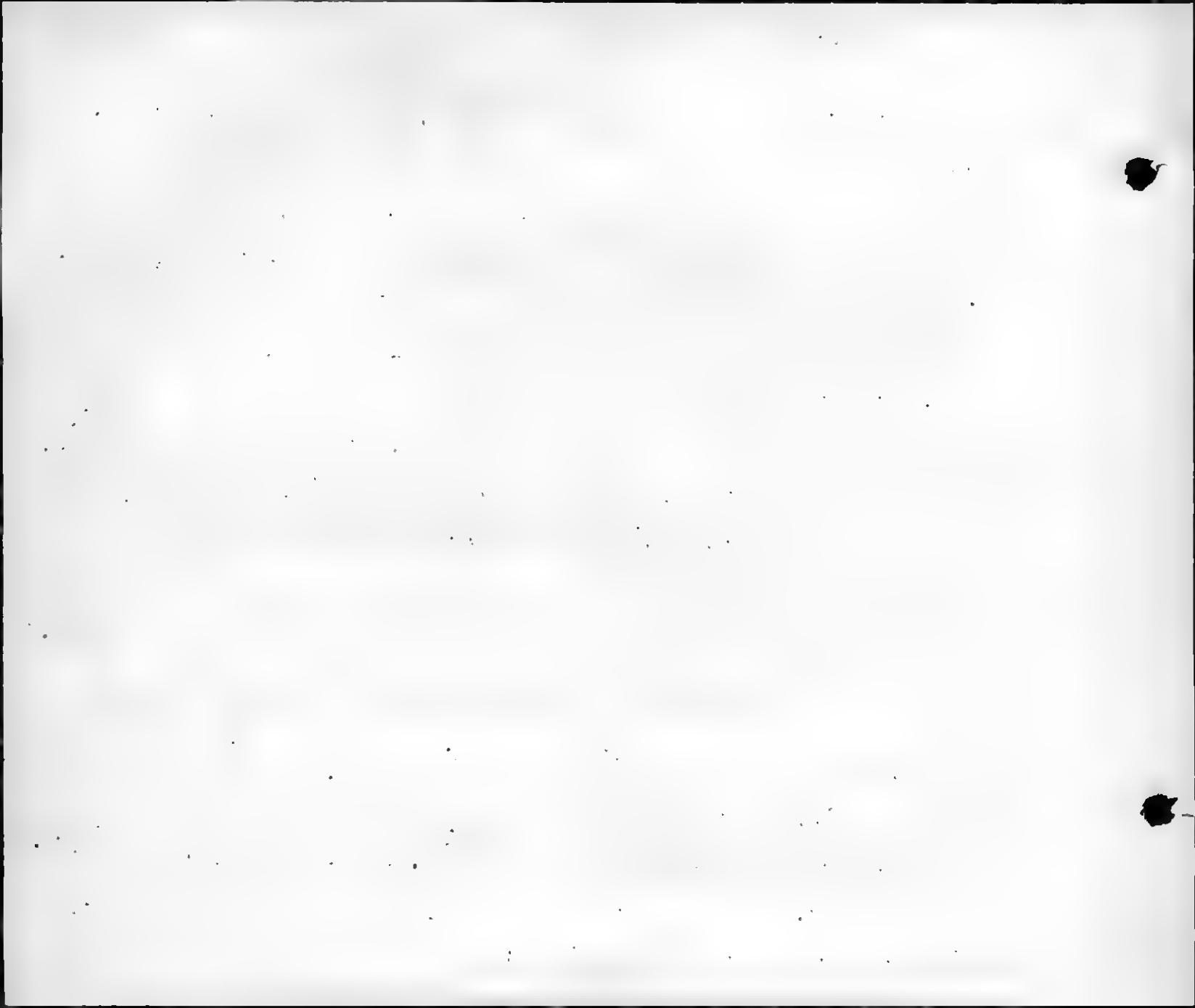
DATE

24b. REGISTRAR'S SIGNATURE

Frank H. Neill

DATE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
 may be retained by the hospital or attending physician and completely filled in by the attending physician and completely filled in by the funeral director.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

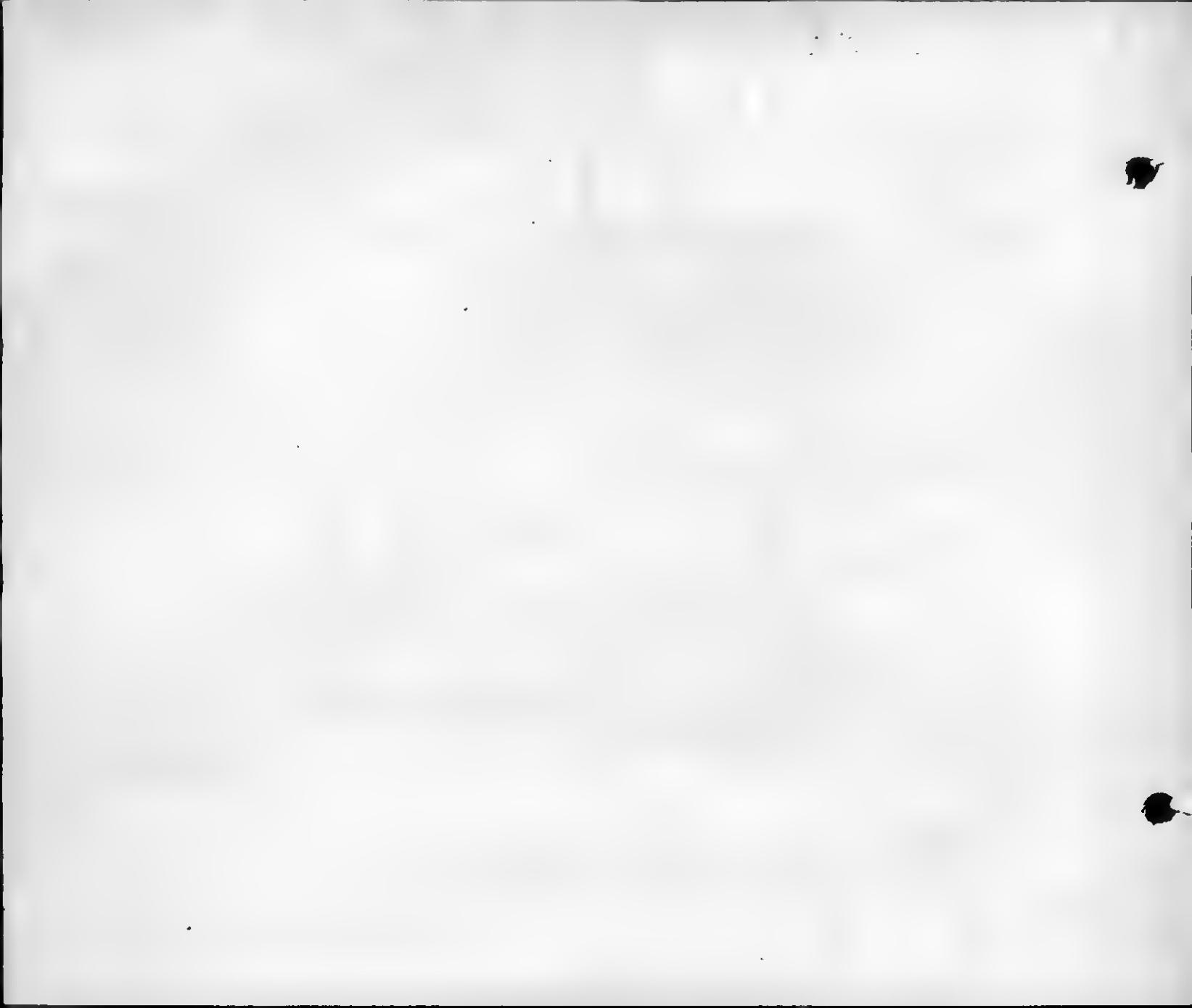
8816

CERTIFICATE OF DEATH

19930

Reg. Dist. No.

| | | | | |
|---|--|--|---|--------------------|
| 1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> | | 2. USUAL RESIDENCE (Where deceased lived if institution, residence before admission) a. STATE <i>Md.</i> | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore 7</i> | | c. LENGTH OF STAY IN 1 st CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>8 month</i> | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR, INSTITUTION <i>Robb Nursing Home, 4105 Essex Rd.</i> | | e. STREET ADDRESS <i>Winans Road</i> | | |
| f. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print) | First <i>Douglas</i> | Middle <i></i> | Last <i>Gray</i> | |
| 4. DATE OF DEATH | Month <i>Aug</i> | Day <i>17</i> | Year <i>1959</i> | |
| 5. SEX <i>M</i> | 6. COLOR OR RACE <i>W</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>Sept 8, 1899</i> | |
| 9. AGE (In years (at birthday) yrs <i>59</i> | 10. IF UNDER 1 YEAR Months <i></i> | 11. IF UNDER 24 HRS. Days <i></i> | 12. Hours <i></i> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>clerk</i> | 10b. KIND OF BUSINESS OR INDUSTRY <i>Gas & Electric Co</i> | 11. BIRTHPLACE (State or foreign country) <i>Baltimore</i> | 12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i> | |
| 13. FATHER'S NAME <i>William Gray</i> | 14. MOTHER'S MAIDEN NAME <i>May</i> | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>yes</i> | | |
| 16. SOCIAL SECURITY NO. <i></i> | 17. INFORMANT <i>Mr. Frederick Robb, 4105 Essex Rd., #7, Md.</i> | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Neumia</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c) | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Asthma, hypertension</i> | | | | |
| 20c. TIME OF INJURY Hour o. m. p. m. | Month 19 | Day | Year | |
| 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i> | 20f. (City or town) <i></i> | (County) <i></i> | (State) <i></i> |
| 21. I certify that I attended the deceased from <i>14 Sept</i> , 1950, to <i>8-17</i> , 1959, that I last saw the deceased alive on <i>8-17</i> , 1959, and that death occurred at <i>9:30 P.M.</i> , from the causes and on the date stated above ADDRESS (Street, city or town, state) <i>1632 Reisters Town Rd.</i> | | | | |
| ACTUAL SIGNATURE <i>Charles H. Williams</i> | DATE SIGNED <i>Charles H. Williams, M.D., Pikesville, Md.</i> | | | |
| PHYSICIAN'S NAME (Type) <i>Charles H. Williams, M.D.</i> | | | | |
| 22a. BURIAL, CREMATION, ETC. DATE THEREOF REMOVAL (Specify) <i>Burial Aug. 30, 1959</i> | 22c. NAME OF CEMETERY OR CREMATORIAL <i>Stone Crayed Cemetery</i> | 22d. LOCATION (City, town, or county) <i>Pikesville, Md.</i> | (State) <i></i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Frank H. Lewis, Pikesville</i> | ADDRESS <i></i> | 24e. REC'D BY REGISTRAR <i>Arthur S. Trahan</i> | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Trahan</i> | DATE SEP 2 2 '59 |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

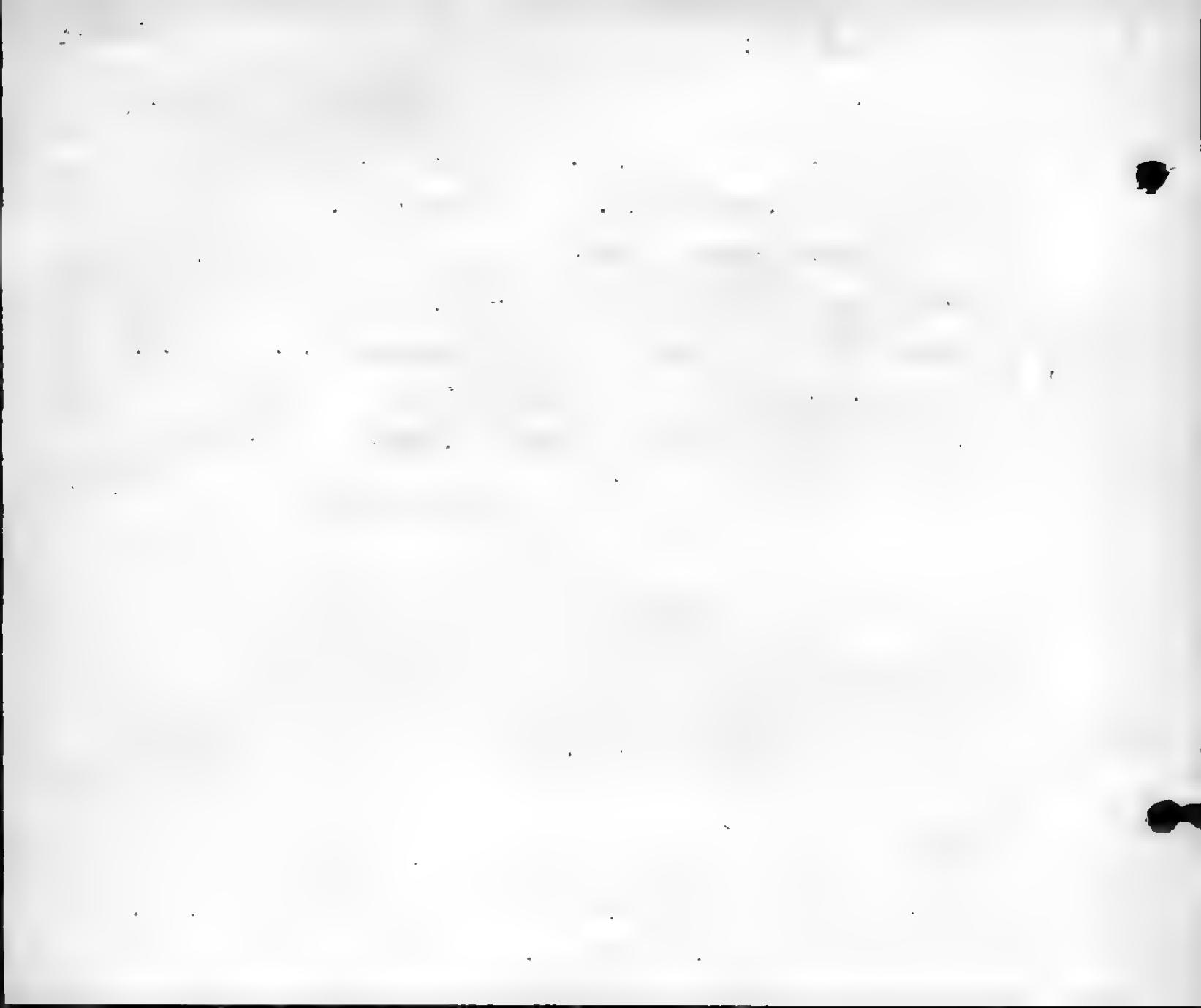
68783

8818

CERTIFICATE OF DEATH

Reg. Dist. No.

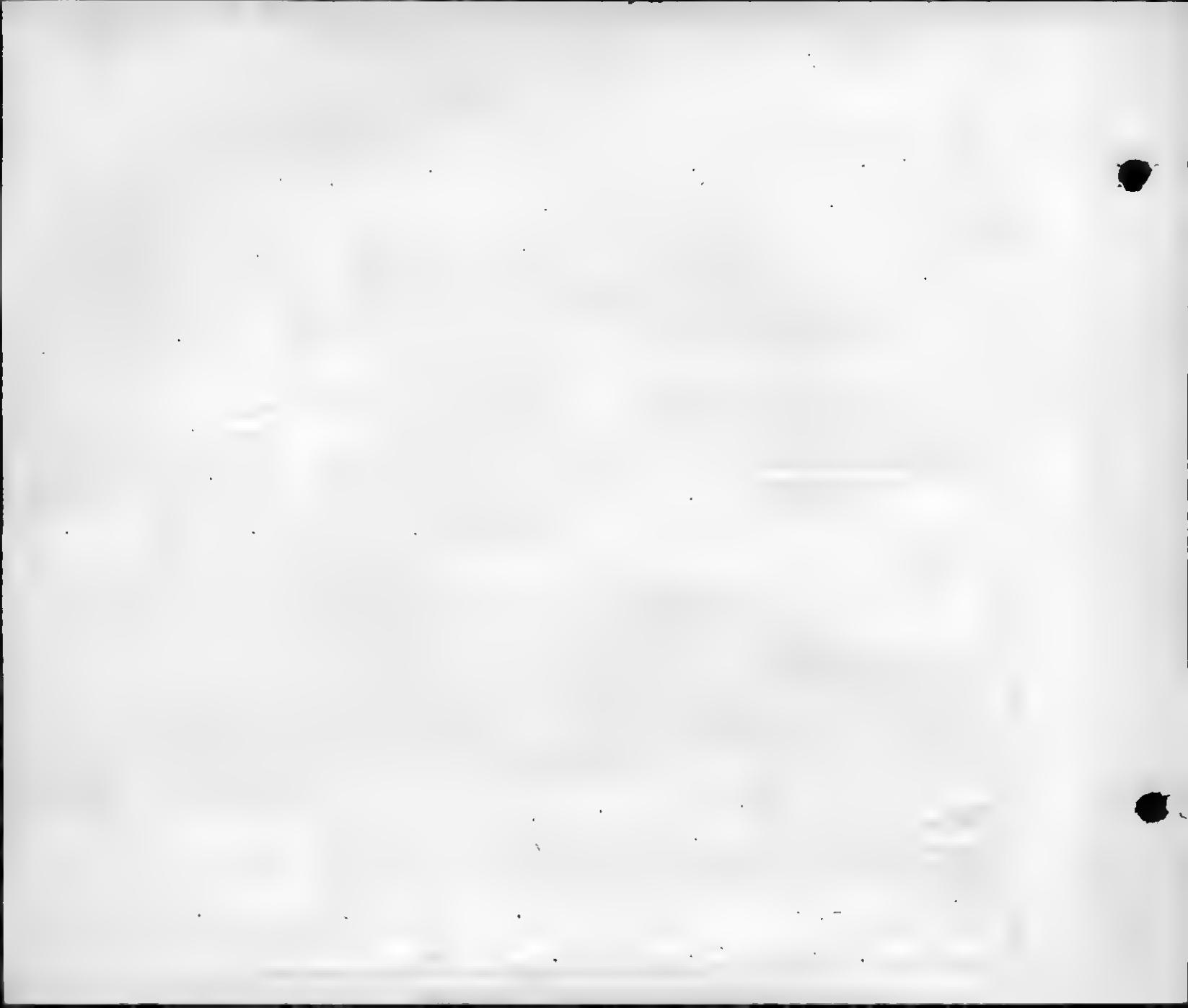
| | | | | | | | |
|--|----------------------------------|---|-----------------|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland | | b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 12, | | c. LENGTH OF STAY IN 1b 2 yrs. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 55 Towson 4, | | d. STREET ADDRESS 7 Cedar Ave. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mercy Villa, Bellona Ave. | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) Jennie Bartley | First Jennie | Middle Green | Last | 4. DATE OF DEATH 8-7-59 | Month 8 | Day 7 | Year 19 |
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 7-4-1879 | 9. AGE (In years lost birthday) 80 yrs. | 10. IF UNDER 1 YEAR Months 0 | 11. IF UNDER 24 HRS Hours 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | 10b. KIND OF BUSINESS OR INDUSTRY home | | 11. BIRTHPLACE (State or foreign country) Washington D.C. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME James W. Bartley | | 14. MOTHER'S MAIDEN NAME ??????? | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. none | |
| | | | | INFORMANT Laurie M. Green | | Address above | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardio-Vascular Disease | | | | | | | |
| DUE TO | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) | | | | | | | |
| DUE TO | | | | | | | |
| (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b) | | | | | |
| 20c. TIME OF INJURY Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>August 1st, 1959</u> to <u>August 7th, 1959</u> , that I last saw the deceased alive on <u>August 7th, 1959</u> , and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above. | | | | | | | |
| ADDRESS (Street, city or town, state) Philip D. Flynn M.D. <u>August 7th, 1959</u> DATE SIGNED ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 8-10-59 | | 22c. NAME OF CEMETERY OR CREMATORIAL Holy Redeemer | | 22d. LOCATION (City, town, or county) Baltimore 6, Md. (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Brooks Funeral Service, Towson 4, Md. | | ADDRESS | | 24a. REC'D BY REGISTRAR DATE AUG 10 '59 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Items 13,14 film 247 8-31-59 et
CERTIFICATE OF DEATH

Reg. Dist. No. 08782

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY <i>Baldo</i> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baldo</i> | | c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baldo</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>7811 Oakleigh</i> | | d. STREET ADDRESS <i>7811 Oakleigh</i> | |
| 3. NAME OF DECEASED (Type or print) <i>Simon</i> | | First <i>Simon</i> | Middle <i>Gregory</i> |
| 4. DATE OF DEATH <i>Aug 24</i> | | Month <i>Aug</i> | Day <i>24</i> |
| 5. SEX <i>Male</i> | | 6. COLOR OR RACE <i>Co.</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 8. DATE OF BIRTH <i>66 yrs</i> | | 9. AGE (In years, months, days, hours, min.) IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Shoemaker</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>—</i> | |
| 11. BIRTHPLACE (State or foreign country) <i>Russia</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>Russian</i> | |
| 13. FATHER'S NAME <i>Unknown</i> | | 14. MOTHER'S MAIDEN NAME <i>Unknown</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>—</i> | | 16. SOCIAL SECURITY NO. <i>—</i> | |
| 17. INFORMANT <i>Wife</i> | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>171X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last <i>Obstetrics and hepatic disease</i> INTERVAL BETWEEN ONSET AND DEATH <i>3 mos.</i> | |
| | | (b) DUE TO <i>Generalized Cognomatous</i> <i>6 mos.</i> | |
| | | (c) <i>AdenoCa. Stomach</i> <i>May 58.</i> | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. p. p. m. <i>June 19 1958</i> | | 20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) <i>Baltimore, Md.</i> | |
| 21. I certify that I attended the deceased from <i>June 19 1958</i> to <i>Aug 24 1959</i> that I last saw the deceased alive on <i>Aug 24 1959</i> and that death occurred at <i>7:00 M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Frank T Kasik Jr.</i> | | ADDRESS (Street, city or town, state) <i>9005 Harford Rd.</i> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 22b. DATE THEREOF <i>8-28-59</i> | |
| 22c. NAME OF CEMETERY OR CREMATORIAL <i>Moreland Mem.</i> | | 22d. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck 5305 Harford Rd.</i> | | 24a. REC'D BY REGISTRAR DATE <i>Aug 27 59</i> | |
| | | 24b. REGISTRAR'S SIGNATURE <i>Charles S. Kline</i> | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

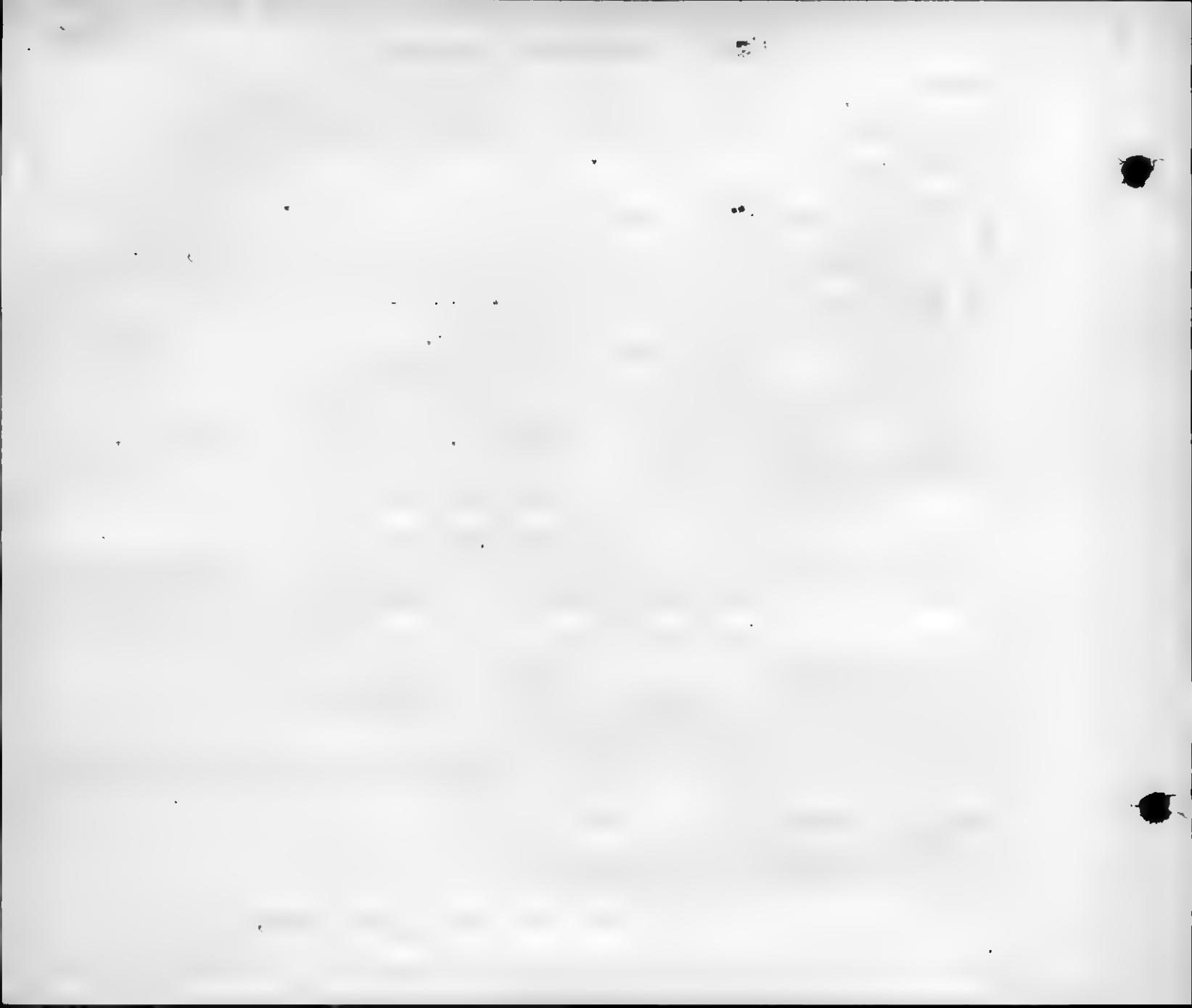
8764

CERTIFICATE OF DEATH

18784

Reg. Dist. No.

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus | | c. LENGTH OF STAY IN 1b 25 Yrs. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1325 Stevens Ave. | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) /Arbutus | |
| 3. NAME OF DECEASED (Type or print) Mary Grikit | | d. STREET ADDRESS 1325 Stevens Ave. | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 4. DATE OF DEATH August 13, 1959 | |
| 5. SEX Female | | First Middle Last | |
| 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH Nov. 21, 1871 | | 9. AGE (In years from birthday) 87 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | |
| 11. BIRTHPLACE (State or foreign country) Latavia | | 12. CITIZEN OF WHAT COUNTRY Latavia | |
| 13. FATHER'S NAME Unknown | | 14. MOTHER'S MAIDEN NAME Unknown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No | | 16. SOCIAL SECURITY NO Seeden A. Grikit 1325 Stevens Ave. | |
| 17. INFORMANT Address | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Arterio Sclerotic Heart Disease 20 yrs. (c) DUE TO Arterio Sclerotic Heart Disease 20 yrs. | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | INTERVAL BETWEEN ONSET AND DEATH 3 days | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) trauma | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Aug. 6, 1959, to Aug. 13, 1959, that I last saw the deceased alive on Aug. 13, 1959, and that death occurred at 11 A.M. from the causes and on the date stated above | | 22. ACTUAL SIGNATURE Ronald R. Lewis M.D. ADDRESS (Street, city or town, State) St. Agnes Hospital 8/14/59 DATE SIGNED 8/14/59 | |
| 23. FURNAL DIRECTOR'S SIGNATURE Ambrose, Inc. 1328 Belvoir Spring | | 24a. REC'D BY REGISTRAR DATE AUG 17 '59 | |
| 24b. REGISTRAR'S SIGNATURE C. J. Lewis | | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8819

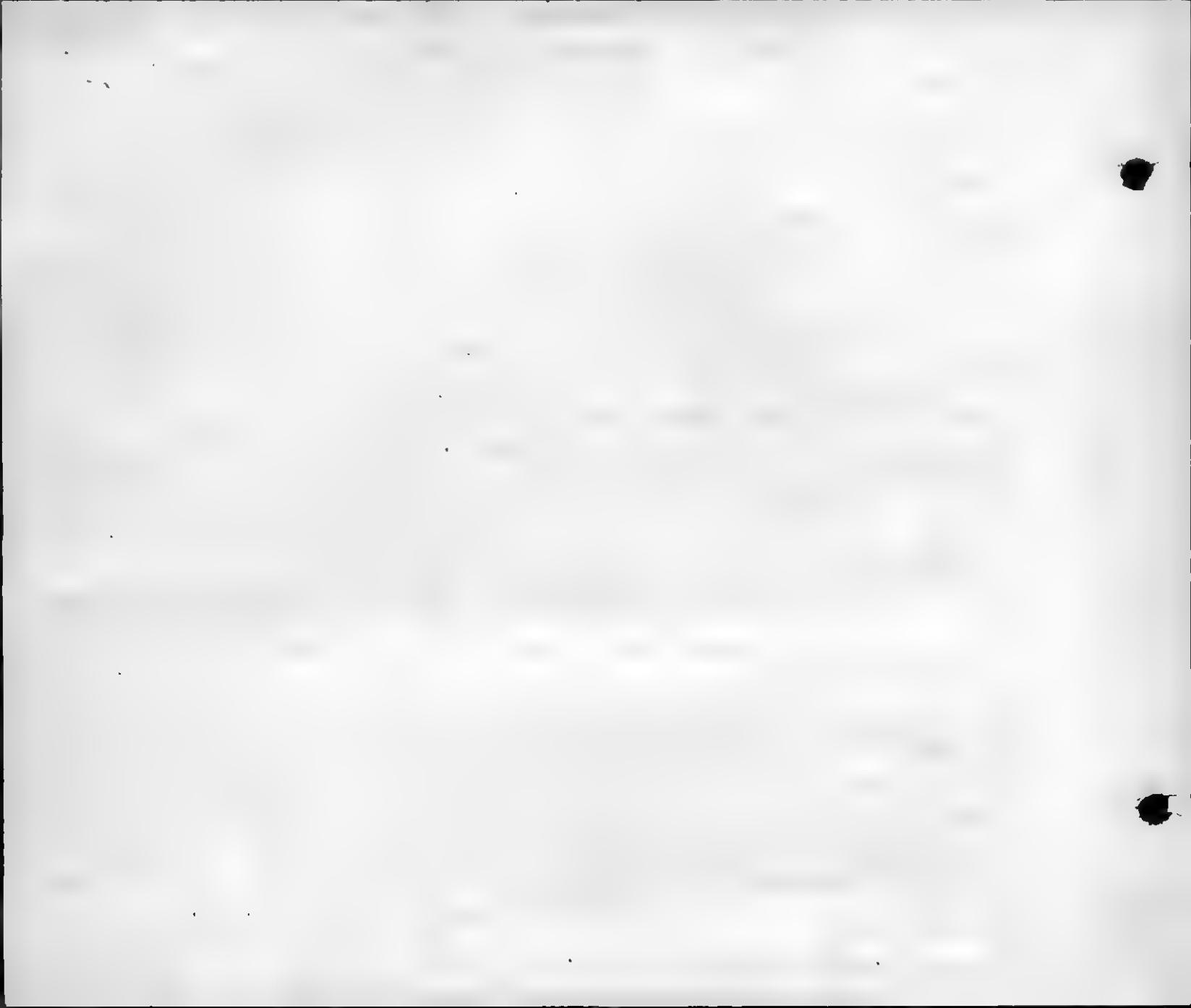
CERTIFICATE OF DEATH

Reg. Dist. No.

08785

| | | | | | | | | | | | | | | | | | |
|---|--|--|--------|--|------------------------|---|-----|---|--|---|-----------------------------------|---|------------------|---|-------------------------------|---|-----------------------------|
| 1. PLACE OF DEATH o COUNTY | | BALTO . | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) | | a. STATE | | Md | | b. COUNTY | | Balto . | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | BALTO . | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | d. STREET ADDRESS | | Balto . | | d. STREET ADDRESS | | e. IS RESIDENCE ON A FARM? | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | 214 Leslie . | | e. STREET ADDRESS | | 214 Leslie . | | e. IS RESIDENCE ON A FARM? | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) | | First | Middle | Lost | 4. DATE OF DEATH | Month | Day | Year | 5. SEX | | 6. COLOR OR RACE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years lost birthday yrs.) | 10. IF UNDER 1 YEAR Months | 11. IF UNDER 24 HRS Hours | 12. IF UNDER 24 HRS Min. |
| fem. | | W | | | Sept 4 1895 | 63 | | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | Maryland | 12. CITIZEN OF WHAT COUNTRY? | USA | | |
| 13. FATHER'S NAME | | Peter Baier | | 14. MOTHER'S MAIDEN NAME | | Laura Rose Walsrum | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yea, no, or unknown) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | | |
| no | | | | | | James J. Gynther / same | | | | | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] | | PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | Congestive Heart Failure | | INTERVAL BETWEEN ONSET AND DEATH | | 4 . . | | DUE TO | | Myocardial degeneration | | 13 yrs | | 30 min. | |
| | | Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. | | (b) | | | | | | DUE TO | | Atherosclerosis? | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | | | | | | | | |
| 21. I certify that I attended the deceased from _____ | | 21. I certify that I attended the deceased from _____ | | 21. I certify that I attended the deceased from _____ | | 21. I certify that I attended the deceased from _____ | | 21. I certify that I attended the deceased from _____ | | 21. I certify that I attended the deceased from _____ | | 21. I certify that I attended the deceased from _____ | | 21. I certify that I attended the deceased from _____ | | 21. I certify that I attended the deceased from _____ | |
| ACTUAL SIGNATURE F. T. KASK JR. | | M.D. | | 9005 Harford Rd | | BALTO 14 MD | | ADDRESS | | ADDRESS | | ADDRESS | | ADDRESS | | DATE SIGNED 8/10/59 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 8-13-59 | | 22c. NAME OF CEMETERY OR CREMATORIUM Forest Glen Mem. Cemetery | | 22d. LOCATION (City, town, or county) Baltimore, Md. | | (State) | | | | | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | | Leonard J. Ruck 5305 Harford Rd. | | 24a. REC'D BY REGISTRAR DATE AUG 11 '59 | | 24b. REGISTRAR'S SIGNATURE Cathleen S. Kraske | | | | | | | | | |

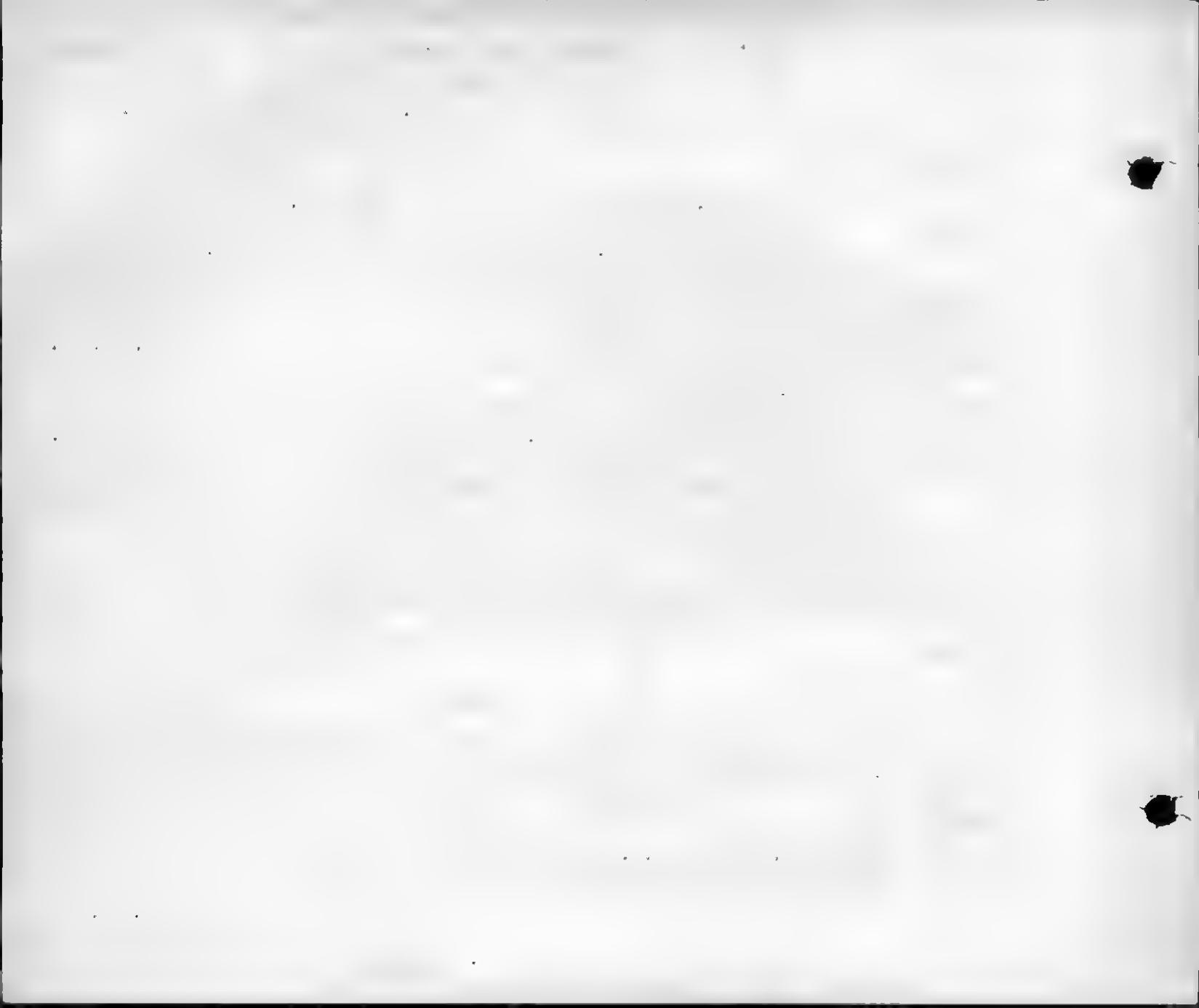
TO HOSPITAL OR ENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 | | | | | | | | | | Reg. Dist. No. 08786 | | | |
|---|--|---|--|--|---|---|-------------------|--|------------|----------------------------|-----------|------------------------------------|--|
| 8820 CERTIFICATE OF DEATH | | | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY | | Baltimore MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) | | | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | Catonsville | | | a. STATE Md. | | b. COUNTY Balto. | | | | | | |
| c. LENGTH OF STAY IN 1b | | 5 yrs | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | Catonsville | | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | 227 Blakeneys Rd. | | | d. STREET ADDRESS | | 227 Blakeneys Rd. | | | | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) | | First James | | Middle S. | | Last Hall | | 4. DATE OF DEATH | Month Aug. | Day 15 | Year 1959 | | |
| 5. SEX M | | 6. COLOR OR RACE W | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH January 14, 1882 | | 9. AGE (In years lost birthday) 77 yrs | | 10. IF UNDER 1 YEAR Months | | 11. IF UNDER 24 HRS Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter | | 10b. KIND OF BUSINESS OR INDUSTRY Self Employed | | 11. BIRTHPLACE (State or foreign country) New York | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | | | | | | |
| 13. FATHER'S NAME James S. Hall | | 14. MOTHER'S MAIDEN NAME Not Known | | | | | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 151X | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address Mrs. Herbert Ganzmann 227 Blakeneys Rd. | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CANCER, STOMACH 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | | (County) | | (State) | | | |
| 21. I certify that I attended the deceased from <u>JULY 7, 1959</u> to <u>AUG. 15, 1959</u> that I last saw the deceased alive on <u>AUG. 15, 1959</u> , and that death occurred at <u>5A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Gilbert E. Rudman, M.D. 2517 W. Baltimore St.</u> DATE SIGNED <u>8-18-59</u> | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>Gilbert E. Rudman, M.D.</u> | | PHYSICIAN'S NAME (Type) | | | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 8-18-59 | | 22c. NAME OF CEMETERY OR CREMATORIAL Wallkill | | 22d. LOCATION (City, town, or county) Phillipsburg, N. Y. (State) | | | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Farley Funeral Home | | ADDRESS Catonsville, Md. | | 24a. REC'D BY REGISTRAR | | 24b. REGISTRAR'S SIGNATURE | | | | | | | |
| DATE AUG 18 1959 | | | | | | | | | | | | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8821

CERTIFICATE OF DEATH

08787

Reg. Dist. No.

| | | | |
|--|------------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) | |
| Baltimore MARYLAND | | a. STATE Md. | b. COUNTY Baltimore |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | c. LENGTH OF STAY IN 1b | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | |
| Lutherville | | Lutherville | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS | |
| 23 Thornhill Rd. | | 23 Thornhill Rd. | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) | First Lillian | Middle E. | Last Hall |
| 4. DATE OF DEATH | Month Aug. | Day 17 | Year 1959 |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Nov. 16, 1885 |
| 9. AGE (In years lost birthday) 73 yrs. | 10. IF UNDER 1 YEAR Months 0 | 11. IF UNDER 24 HRS Days 0 | 12. IF UNDER 24 HRS Hours 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Valentine Schoenig | | 14. MOTHER'S MAIDEN NAME Barbara Mueller | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. INFORMANT Frederick Hall | |
| 17. ADDRESS | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 440X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO Hypertensive heart disease (c) | |
| INTERVAL BETWEEN ONSET AND DEATH 2 days | | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | |
| 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | 20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. | |
| 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 8/1/59, 19, to 8/17/59, 19, that I last saw the deceased alive on 9/23/59, 19, and that death occurred at 9:29 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) | | DATE SIGNED 8/17/59 | |
| ACTUAL SIGNATURE Walt Van Reenen | | M.D. | |
| PHYSICIAN'S NAME (Type) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 8-20-59 | 22c. NAME OF CEMETERY OR CREMATORIUM Greenmount Cem. | 22d. LOCATION (City, town, or county) (State) Baltimore, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck 5305 Harford Rd. | | ADDRESS | 24a. REC'D BY REGISTRAR DATE AUG 1 1959 |
| | | | 24b. REGISTRAR'S SIGNATURE Sister S. K. |

TO HOSPITAL OR ENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 8822

CERTIFICATE OF DEATH

08788

Reg. Dist. No.

| | | | | |
|---|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | c. LENGTH OF STAY IN 1b 3yr22dys | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) | First Sarah | Middle Elizabeth | Last Hall | |
| 4. DATE OF DEATH | Month August | Day 7 | Year 1959 | |
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH October 20, 1884 | |
| 9. AGE (In years last birthday) 74 yrs | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | 11. BIRTHPLACE (State or foreign country) Maryland | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Governor Winsor | 14. MOTHER'S MAIDEN NAME Elizabeth Langley | Address | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) unknown | 16. SOCIAL SECURITY NO. Unknown | 17. INFORMANT Records: SPRING GROVE STATE HOSPITAL | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 447 A.A DUE TO Terminal uremia | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO Arteriosclerotic nephrosclerosis | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) (c) Arteriosclerotic cardiovascular disease | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from July 13, 1956, to Aug. 7, 1959, that I last saw the deceased alive on Aug. 7, 1959, and that death occurred at 12:30 a.m. from the causes and on the date stated above | | | | ADDRESS (Street, city or town, state) |
| ACTUAL SIGNATURE <i>Stella Wachsler</i> | M.D. | DATE SIGNED 8-7-59 | | |
| PHYSICIAN'S NAME (Type) Stella Wachsler, M. D. | SPRING GROVE STATE HOSPITAL | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 8/11/59 | 22c. NAME OF CEMETERY OR CREMATORIUM St Mary's Cemetery | 22d. LOCATION (City, town, or county) Upper Marlboro Md. | (State) |
| 23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons | ADDRESS Hyattsville Md. | 24a. REC'D BY REGISTRAR AUG 12 '59 | 24b. REGISTRAR'S SIGNATURE Clifford S. Kline | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08789

Reg. Dist. No.

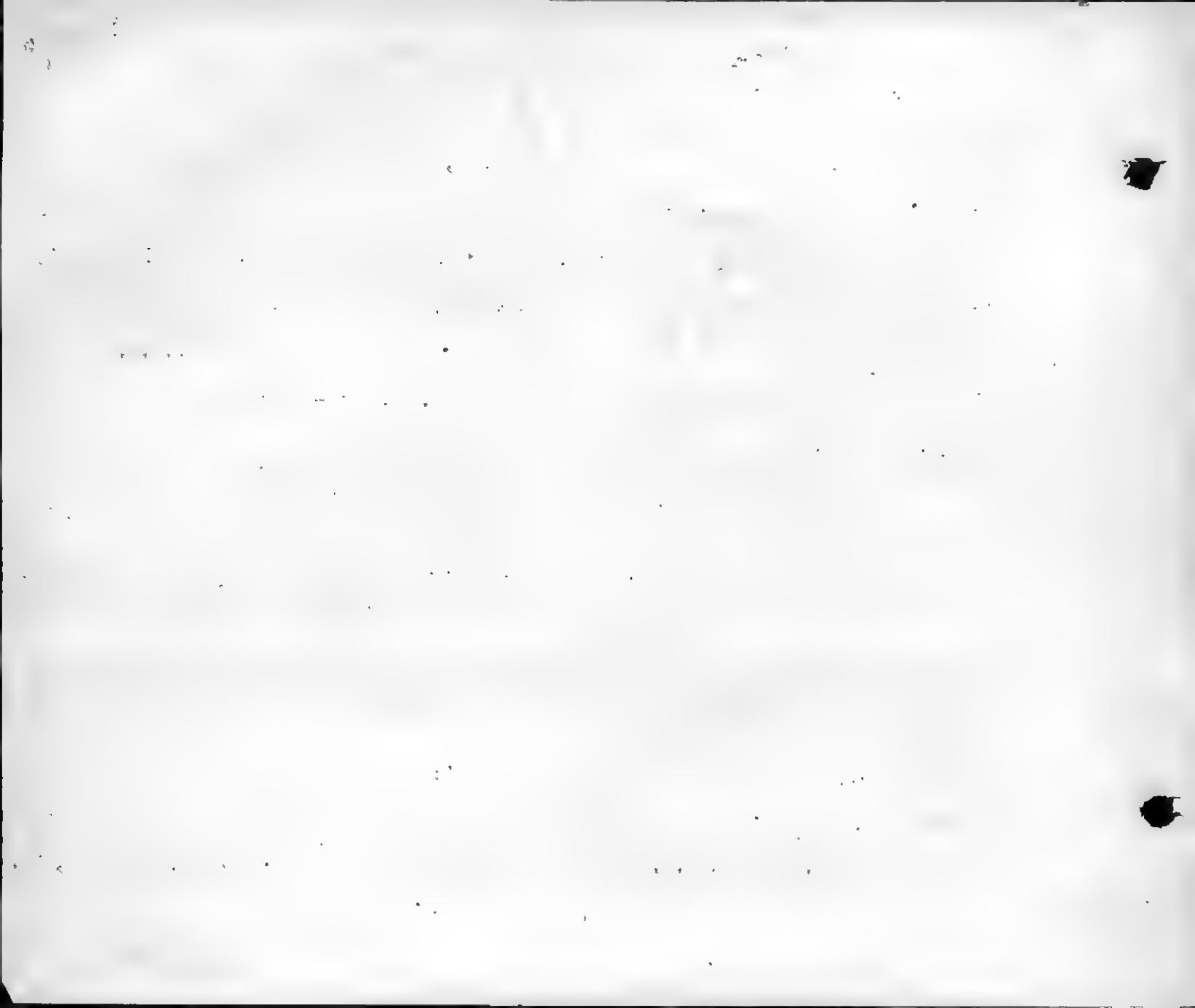
8823

CERTIFICATE OF DEATH

TO HOSPITAL OR ENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

| | | | |
|--|---------------------------------------|---|------------------------------|
| 1. PLACE OF DEATH a. COUNTY Rosewood State Training School Baltimore, Maryland | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY City | |
| b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Owings Mills, Maryland | | c. LENGTH OF STAY IN 1b 43 years | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rosewood State Training School | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | First Walton | Middle Wallace | Last Hall |
| 4. DATE OF DEATH 8 | Month Aug | Day 19 | Year 1959 |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 10/11/07 |
| 9. AGE (In years last birthday) 51 yrs. | 10. IF UNDER 1 YEAR Months Days | 11. IF UNDER 24 HRS Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Maryland | |
| 13. FATHER'S NAME William I. Hall - deceased | | 14. MOTHER'S MAIDEN NAME Mary G. Walton - deceased | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. INFORMANT Rosewood Records | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause, if any. (b) DUE TO Arterio - sclerosis, Senile - | | INTERVAL BETWEEN ONSET AND DEATH 24 days | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE COND T ON GIVEN IN PART I (c) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from _____, 19____, to 8/19/59, 19____, that I last saw the deceased alive on 8/19/59, 19____, and that death occurred at 7:40a. M. from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) DATE SIGNED 8/19/59 | |
| ACTUAL SIGNATURE Harry G. Butler, M.D. | | 22. NAME OF CEMETERY OR CREMATORIUM Rosewood Training School, Owings Mills, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Aug 19, 1959 | | 22b. LOCATION (City, town, or county) Baltimore, Md. (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Frank H. Harvey | | 24a. REC'D BY REGISTRAR DATE AUG 20 '59 | |
| ADDRESS | | 24b. REGISTRAR'S SIGNATURE Harry G. Butler | |



TO HOSPITAL OR ENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 32 08790

| | | | | | | |
|--|--|--|--|--|---|---------|
| 1. PLACE OF DEATH a. COUNTY Baltimore | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MD | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson | | b. COUNTY CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE CITY | | | | |
| c. LENGTH OF STAY IN 1b 2005 MONTEBELLO | | d. STREET ADDRESS 2005 MONTEBELLO | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print) WILLIAM | | First | Middle | | | |
| 4. DATE OF DEATH HARMAN | | Month | Day | | | |
| 5. SEX M | | 6. COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | |
| 8. DATE OF BIRTH 4-23-94 | | 9. AGE (In years last birthday) 05 | 10. IF UNDER 1 YEAR Months 0 Days 0 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) MAINTENANCE | | 10b. KIND OF BUSINESS OR INDUSTRY BETH-STEEL | 11. BIRTHPLACE (State or foreign country) VIRGINIA | | | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME GRAT HARMAN | | | | |
| 14. MOTHER'S MAIDEN NAME HATTIE WHITE | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | | | |
| 16. SOCIAL SECURITY NO 236-10-3336 | | 17. INFORMANT Hospital Records, Mt. Wilson State Hospital | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ADVANCED PULMONARY TUBERCULOSIS | | INTERVAL BETWEEN ONSET AND DEATH 1 month | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) COR PULMONALE | | | | | | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour 0. m. Day 19 Year 1957 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hartwell Cem. | 20f. (City or town) Hartwell, W. Va. | (County) | (State) |
| 21. I certify that I attended the deceased from 11-7 , 1957, to 8-9 , 1957, that I last saw the deceased alive on 8-9-57 , 1957, and that death occurred at 5:20 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) William Newcomer, M.D., Mt. Wilson, Maryland | | | | DATE SIGNED | | |
| ACTUAL SIGNATURE William Newcomer | | PHYSICIAN'S NAME (Type) William Newcomer, M.D. | | Superintendent | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 8-14-59 | 22c. NAME OF CEMETERY OR CREMATORIAL Hartwell Cem. | 22d. LOCATION (City, town, or county) Hartwell, W. Va. | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck 5305 Harford Rd. | | ADDRESS Leonard J. Ruck 5305 Harford Rd. | 24a. REC'D BY REGISTRAR DATE AUG 13 '59 | | 24b. REGISTRAR'S SIGNATURE Edith S. Kline | |

BLITZER (111)
NON-BELIEVER

THATMAN
-2-2-2-2-2
MAINLINE REEL-SEER SERIES
GREAT MARY HALLIE DWHITE

THATMAN BY LUCY AYL
LUCILLE LOUISE

CCR LUCY AYL

CCR LUCY AYL 1-1-1-1-1-1-1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08791

8825

CERTIFICATE OF DEATH

Reg. Dist. No

1. PLACE OF DEATH

o. COUNTY

Baltimore

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)

o. STATE

Maryland

b. COUNTY

Baltimore

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

c. LENGTH OF STAY IN 1b

Lutherville

d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION

Bellona & Division Avenues

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Lutherville

d. STREET ADDRESS

Bellona & Division Avenues

e. IS RESIDENCE
ON A FARM?YES NO 3. NAME OF
DECEASED
(Type or print)First
WILLIAM
MIDDLE
ELSWORTH
LAST
MARR4. DATE
OF
DEATH

August 7, 1959

Month
Day
Year
19

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

May 9, 1895

9. AGE (In years
lost birthday)

64

yrs.

10. IF UNDER 1 YEAR

Months
Days

11. IF UNDER 24 HRS

Hours
Min10b. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

Horse Transportation

10b. KIND OF BUSINESS OR INDUSTRY

Self Employed

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

J. George Marr

14. MOTHER'S MAIDEN NAME

Catherine Dearholt

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

INFORMANT

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

420.1

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.

DUE TO

(b)

DUE TO

(c)

acute coronary of thrombosis 15 minutes
Coronary with occlusion 5 yrsINTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19
p. m.20d. INJURY OCCURRED
While at work Not while at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)20f. (City or town)
(County) (State)19. WAS AUTOPSY
PERFORMED?
YES NO 21. I certify that I attended the deceased from July 1, 1955 to Aug 7, 1959, that I last saw the deceased
alive on Aug 7, 1959, and that death occurred at 6:30 A.M. from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATUREPHYSICIAN'S
NAME (Type)

G. T. Gilmore

22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial Aug. 11, 1959 22b. DATE THEREOF
22c. NAME OF CEMETERY OR CREMATORIUM
Grace Methodist Cemetery 22d. LOCATION (City, town, or county) (State)
Cockeysville, Balto. Co., Md.

23. FUNERAL DIRECTOR'S SIGNATURE

John Burns' Sons, Towson, Maryland

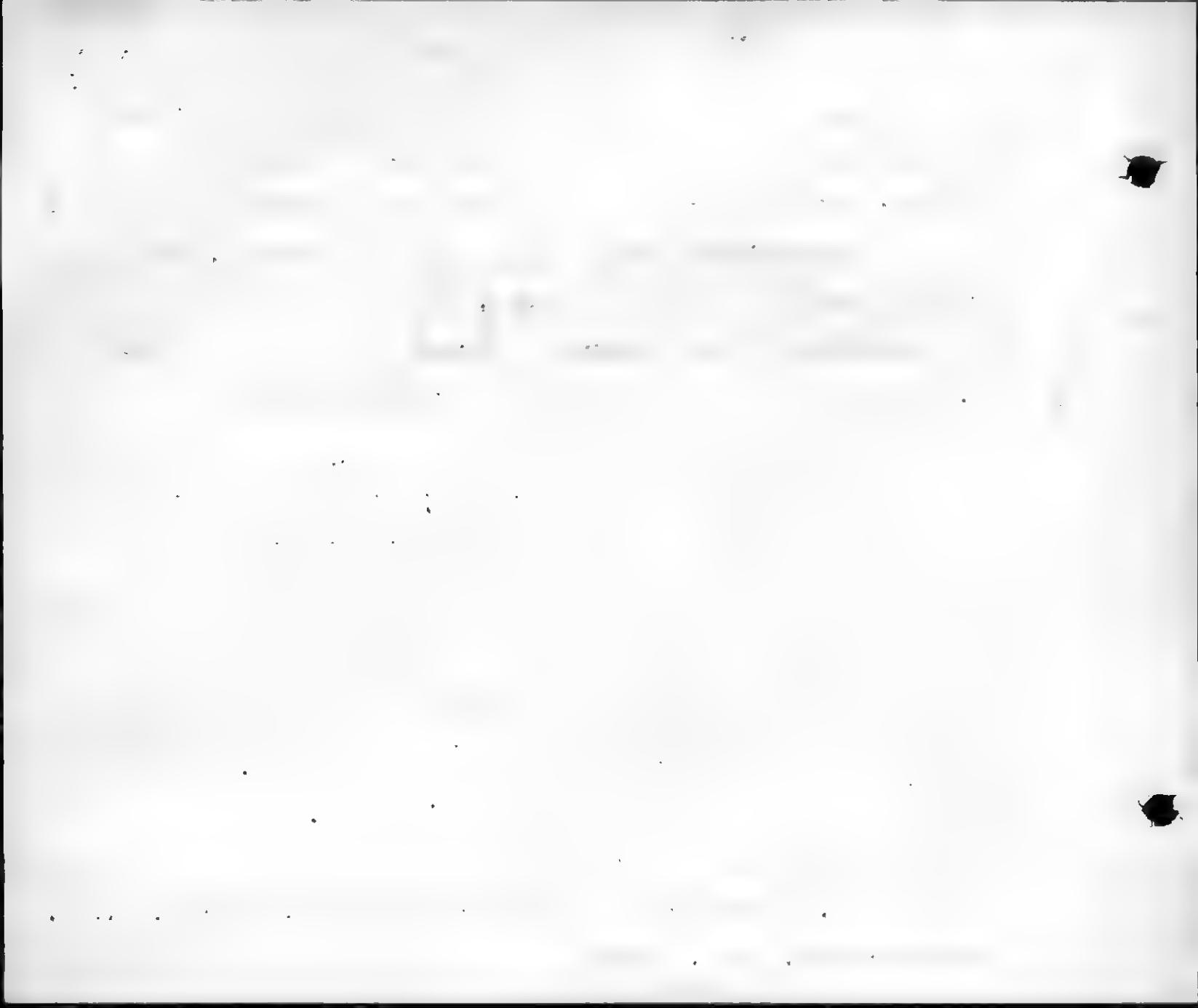
ADDRESS

24a. REC'D BY REGISTRAR

DATE AUG 13 '59

24b. REGISTRAR'S SIGNATURE

C. Burns, Esq.



TO HOSPITAL OR ENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial; cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8826

CERTIFICATE OF DEATH

08792

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY

Baltimore

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Rural Catonsville

c. LENGTH OF STAY IN 1b

7 months

d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION

Forrest Haven Nursing

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Md.

b. COUNTY

Baltimore

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

X Pikesville 8,

d. STREET ADDRESS

3 Warren Road

e. IS RESIDENCE
ON A FARM?

YES NO

2910
3. NAME OF
DECEASED
(Type or print)

First
Nellie

Middle
Mary

Last
Hartman

4. DATE
OF
DEATH

Month
August

Day
27

Year
1959

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

Female

White

WIDOWED

DIVORCED

April 11, 1876

9. AGE (In years
last birthday)
83
yrs

10. IF UNDER 1 YEAR
Months
Days

IF UNDER 24 HRS
Hours
Min

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

Own Home

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Bartholemew Cashman

14. MOTHER'S MAIDEN NAME

Bridget Hanley

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)

16. SOCIAL SECURITY NO.
(If yes, give war, dates of service)

17. INSTITUTION

No

None

Mr. Harry J. Hartman, 3 Warren Rd.

Address
Pikesville 8, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

422.1

DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.

(b)

ACUTE ACCELERATED CARDIO-URINARY

DISEASE

(c)

HEART FAILURE

INTERVAL BETWEEN
ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?

YES NO

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(If either, notify MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19
p. m.

20d. INJURY OCCURRED
While Not while
at work at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from

8/1, 1959, to

8/27, 1959, that I last saw the deceased

alive on

8/27, 1959

and that death occurred at

4:30 P.M.

from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATURE

John H. Showman

M.D.

5800 Edmonson Ave

8/29/59

PHYSICIAN'S
NAME (Type)

John H. Showman

5800 Edmonson Ave

8/29/59

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

Aug. 31, 1959

22c. NAME OF CEMETERY OR CREMATORIUM

Druid Ridge Cemetery

22d. LOCATION (City, town, or county)

Pikesville 8, Md.

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

Frank J. Newell, Pikesville 8,

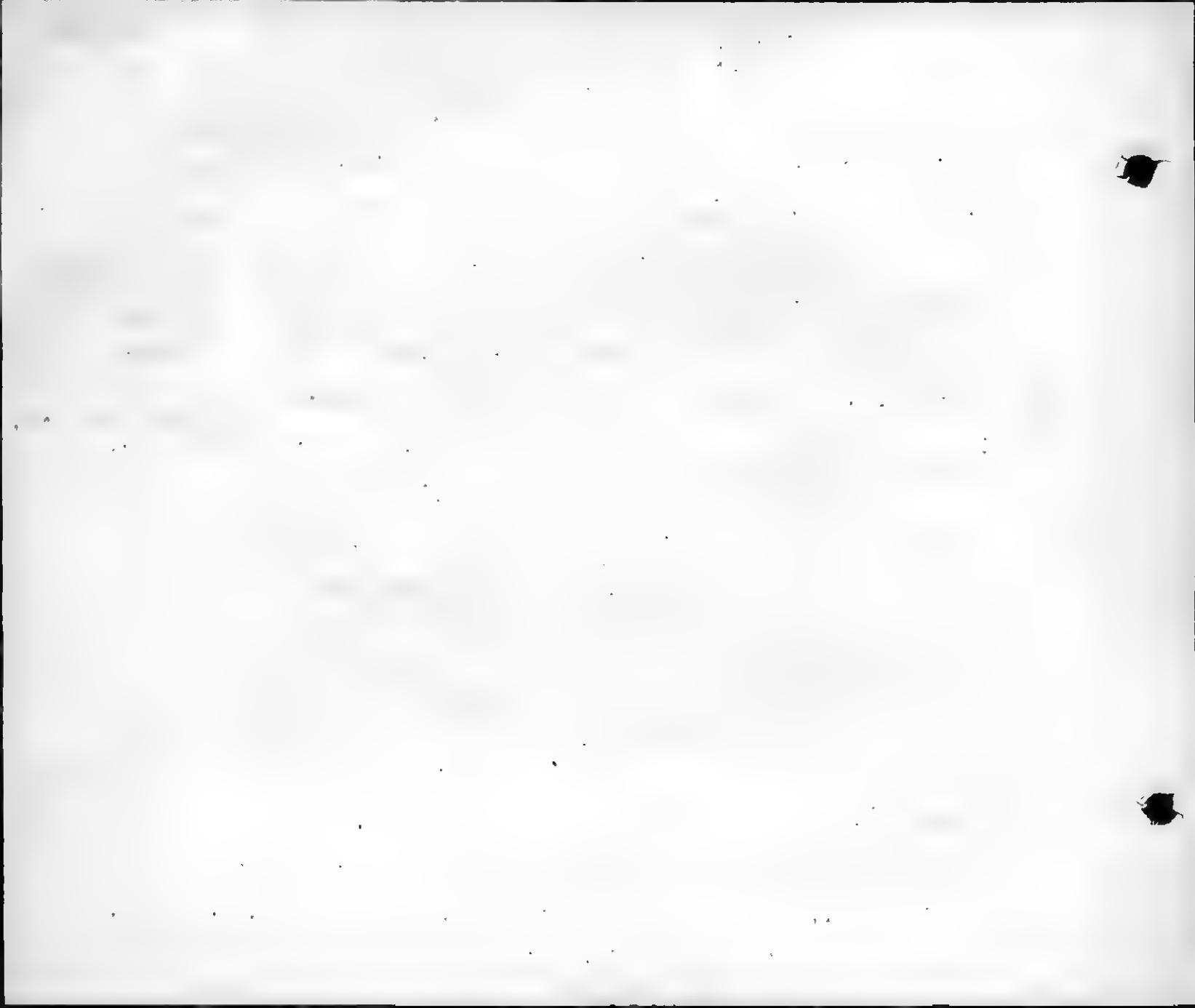
24a. REC'D BY REGISTRAR

DATE SEP 3 '59

24b. REGISTRAR'S SIGNATURE

Charles S. Krause

VS A15 (4)
15M 9/58



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08793

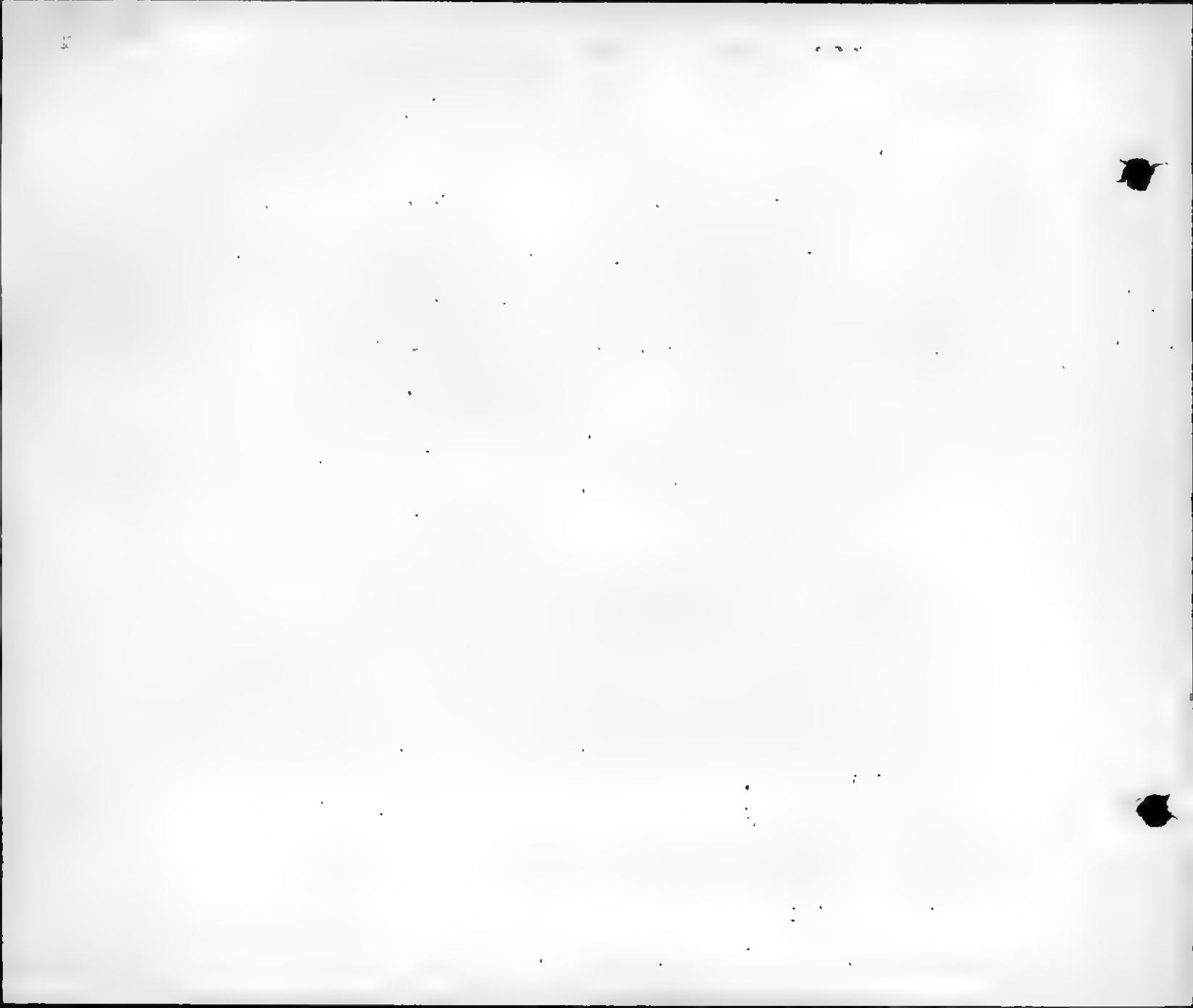
8827

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | | |
|--|--|---|--|---|---|---|------------------------|-----------------------|
| 1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i> | | c. LENGTH OF STAY IN 1b <i></i> | | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>8604 Harford Rd.</i> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | |
| 3. NAME OF DECEASED (Type or print) | First <i>Ralph</i> | Middle <i>Lee</i> | Last <i>Hartman</i> | | | | | |
| 4. DATE OF DEATH | Month <i>Aug.</i> | Day <i>6,</i> | Year <i>1959</i> | | | | | |
| 5. SEX <i>male</i> | 6. COLOR OR RACE <i>white</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>5-23-1893</i> | | | | | |
| 9. AGE (In years lost birthday) <i>66 yrs.</i> | 10. IF UNDER 1 YEAR Months <i></i> | 11. IF UNDER 24 HRS. Days <i></i> | 12. IF UNDER 24 HRS. Hours <i></i> | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ret.</i> | 10b. KIND OF BUSINESS OR INDUSTRY <i>Balto. Transit</i> | 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | | | | |
| 13. FATHER'S NAME <i>George Hartman</i> | 14. MOTHER'S MAIDEN NAME <i>Laura Harker</i> | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i></i> | 16. SOCIAL SECURITY NO (If yes, give war or dates of service) <i>413-10-1010</i> | INFORMANT <i>Anna Hartman</i> | Address <i>same</i> | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY- IMMEDIATE CAUSE (a) <i>161X</i> DUE TO <i>Murphy's Caesum of lungs</i> | | | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH <i>24h</i> | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) (c) | | DUE TO | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION G.VEN IN PART I(a) | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20c. TIME OF INJURY Hour o. m. p. m. | Month <i>Oct.</i> | Day <i>19</i> | Year <i>1959</i> | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) <i>8604 Parkwood</i> | 20f. (City or town) <i>Baltimore</i> | (County) <i>Md.</i> | (State) <i>Md.</i> |
| 21. I certify that I attended the deceased from <i>10 Oct.</i> , 1959, to <i>5 Aug.</i> , 1959, that I last saw the deceased alive on <i>5 August</i> , 1959, and that death occurred at <i>1A</i> M. from the causes and on the date stated above. | | | | ADDRESS (Street, city or town, state) <i>8604 Parkwood</i> | | DATE SIGNED <i>6 Aug. 59</i> | | |
| ACTUAL SIGNATURE <i>Howard Goodman</i> | | PHYSICIAN'S NAME (Type) <i>Howard Goodman</i> | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | 22b. DATE THEREOF <i>8-8-59</i> | 22c. NAME OF CEMETERY OR CREMATORIAL <i>Parkwood</i> | 22d. LOCATION (City, town, or county) <i>Baltimore, Md.</i> | (State) <i>Md.</i> | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i> | | ADDRESS <i>5305 Harford Rd.</i> | 24a. REC'D BY REGISTRAR DATE <i>AUG 7 '59</i> | 24b. REGISTRAR'S SIGNATURE <i>Cathleen S. Turner</i> | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 1
may be retained by the hospital or attending physician.
1. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to a burial, cremation, or removal, and in any event within 72 hours after death.



1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

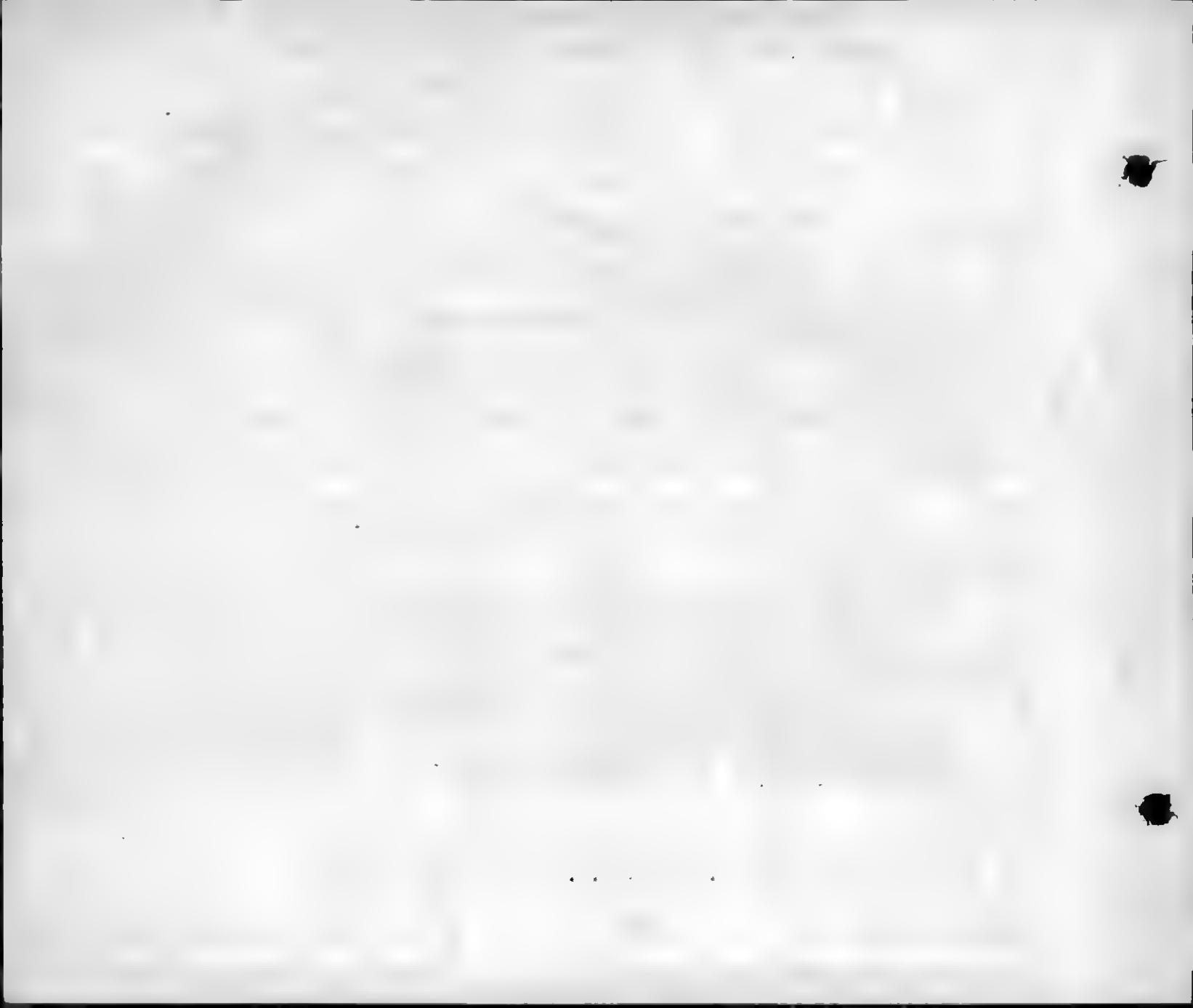
09938

8828

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE Maryland | | b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson | | c. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 213 Courtland Avenue | | d. STREET ADDRESS 213 Courtland Avenue | | e. DATE OF DEATH August 6 1959 | | Month Day Year | |
| 3. NAME OF DECEASED (Type or print) WILLIAM PHILIP HEBERT | | First Middle Last | | 4. DATE OF DEATH August 6 1959 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 9. AGE (In years last birthday) 54 yrs. | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> INTERVAL BETWEEN ONSET AND DEATH DUE TO <u>Arteriosclerotic Heart Disease.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Hour a. m. p. m. | | Month, Day, Year 19 | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) Charles S. Petty | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED 8/6/59 | | | |
| 22a. BURIAL* CREMATION, REMOVAL (Specify) Cremation | | 22b. DATE THEREOF 9-8-59 | | 22c. NAME OF CEMETERY OR CREMATORY U. of Med. Med. School | | 22d. LOCATION (City, town, or county) Baltimore, Md. (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Charles S. Petty | | ADDRESS | | 24a. REC'D BY REGISTRAR DATE SEP 10 '59 | | 24b. REGISTRAR'S SIGNATURE Charles S. Petty | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8829

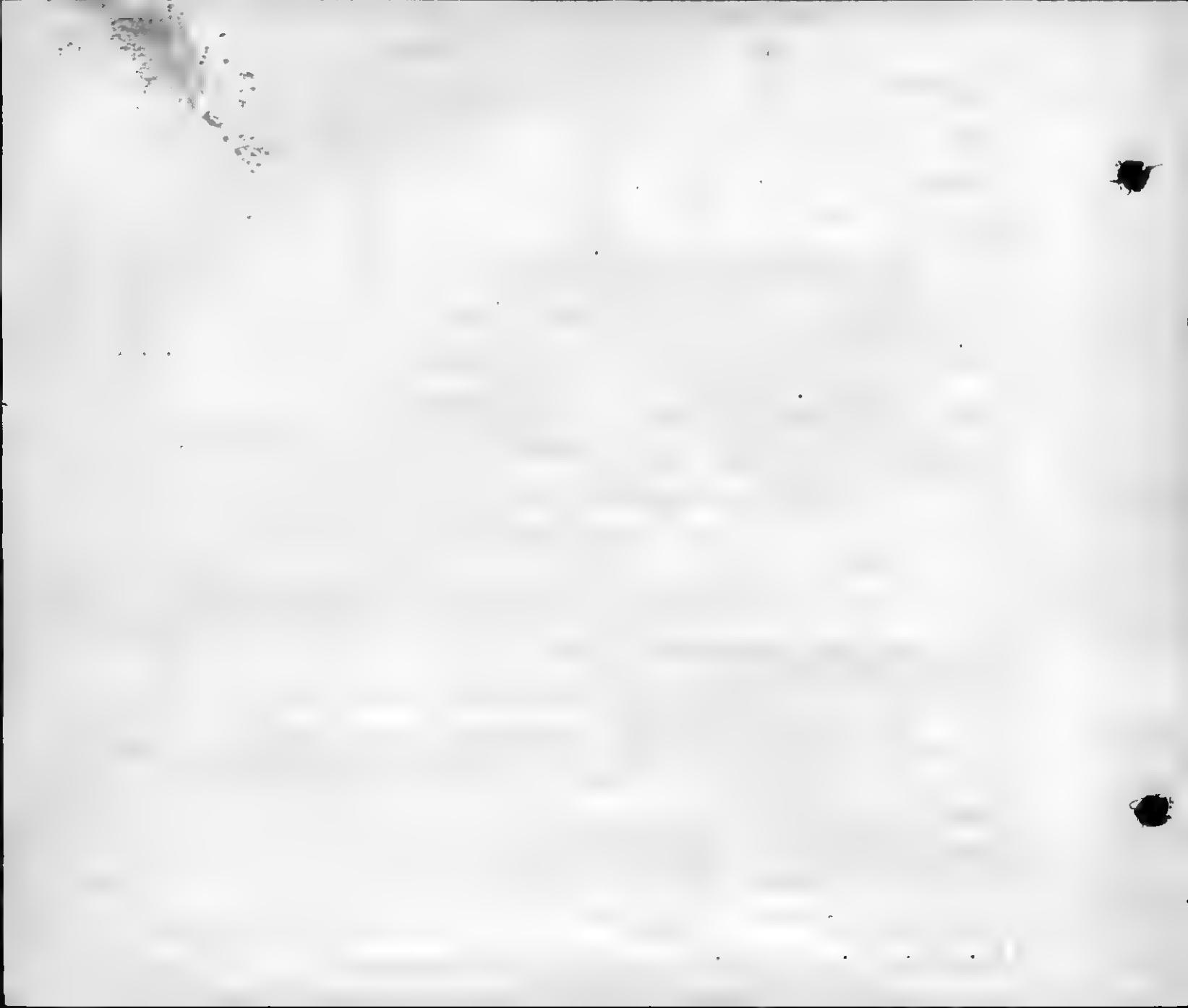
Item 2 File No. 8-2459 et

CERTIFICATE OF DEATH

08794

Reg. Dist. No.

| | | | | | |
|--|--|---|---|--|------------------------------------|
| 1. PLACE OF DEATH a. COUNTY | | Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) | |
| | | | | a. STATE Maryland | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. LENGTH OF STAY IN 1b | | b. COUNTY | |
| Towson | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | f. STREET ADDRESS | |
| Aged Women's & Aged Men's Home 625 Chestnut Avenue | | Towson / Baltimore 29 | | 327-C Collins Avenue | |
| g. STREET ADDRESS | | h. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | i. IS RESIDENCE ON A FARM? | |
| 625 Chestnut Ave | | Towson | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | | First | Middle | Lost | 4. DATE OF DEATH |
| Florence | | | M. | Henderson | Month Day Year |
| 5. SEX | | 6. COLOR OR RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years lost birthday) |
| FEMALE | | White | WIDOWER <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | Jan. 14, 1883 | 76 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Housewife | | | | Baltimore | |
| 12. CITIZEN OF WHAT COUNTRY? | | U.S.A. | | | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | | |
| Richard J. Warnick | | Melvina McKean | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| | | | | Address Aged Women's & Aged Men's Home, Towson | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | | | | |
| DUE TO Rupture abdominal Aneurysm 76 hrs | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO arteriosclerotic cerebral-vascular disease 5 yrs | | | | | |
| C (c) | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>January</u> , 19 <u>59</u> , to <u>August 15</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>August 14</u> , 19 <u>59</u> , and that death occurred at <u>11 a.m.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>11-8-33rd St. Baltimore</u> DATE SIGNED <u>Aug 17 1959</u> | | | | | |
| ACTUAL SIGNATURE <u>Edward E. Day M.D.</u> | | | | | |
| PHYSICIAN'S NAME (Type) <u>Edward E. Day M.D.</u> | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 8-18-59 | | 22c. NAME OF CEMETERY OR CREMATORIAL Baltimore Cemetery | |
| 22d. LOCATION (City, town, or county) Baltimore | | (State) | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul Street, Zone 2 | | ADDRESS | | 24a. REC'D BY REGISTRAR DATE AUG 18 '59 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Cathleen S. Krause | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8830
CERTIFICATE OF DEATH

08795

Reg. Dist. No.

| | | | | | | | | |
|---|--|--|---|---|---|--|---------------------------------------|---------------|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7012 York Road | | | | d. STREET ADDRESS 7012 York Road #12 | | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) | | First HELEN | Middle B. | Last HEROLD | 4. DATE OF DEATH | Month August | Day 5 | Year 19 59 |
| 5. SEX Female | | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Oct. 31, 1890 | 9. AGE (In years last birthday) 68 yrs. | 10. IF UNDER 1 YEAR Months | 11. IF UNDER 24 HRS Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? | | |
| 13. FATHER'S NAME Alexander Bond | | | | 14. MOTHER'S MAIDEN NAME Cora McAfee | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address Mrs. H. Irving Mettee-7012 York Road #12 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c) | | | | Carcinoma of Rectum with Metastases to Liver | | INTERVAL BETWEEN ONSET AND DEATH 8 mo | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY Hour o. m. p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) M. D. | (County) | (State) | |
| 21. I certify that I attended the deceased from Oct. 1957 to Aug. 1957 that I last saw the deceased alive on Aug. 25, 1957, and that death occurred at 5 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) M. D. DATE SIGNED M. D. 1957 | | | | | | | | |
| PHYSICIAN'S NAME (Type) Lorraine Park Cemetery | | 22a. DATE THEREOF 8/8/59 | | | | | | |
| 22b. NAME OF CEMETERY OR CREMATORIUM Lorraine Park Cemetery | | 22c. LOCATION (City, town, or county) Woodlawn, Maryland | | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Tracy | | 24a. REC'D. BY REGISTRAR AUG 7 1959 | | | | | | |
| ADDRESS 17012 York Road #12, Md. | | 24b. REGISTRAR'S SIGNATURE Arthur S. Tracy | | | | | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08796

8831

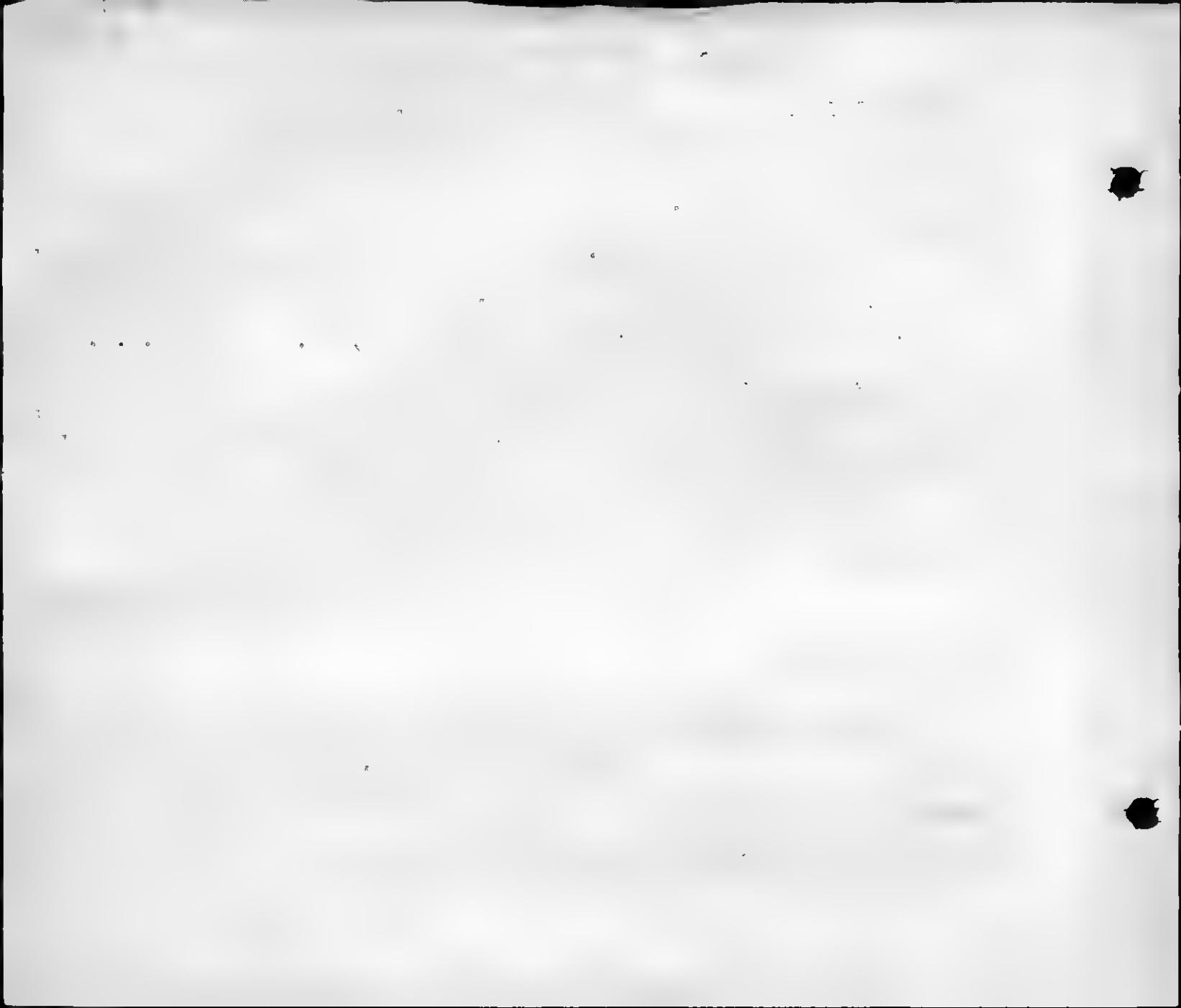
CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | |
|---|---------------------------|--|--|--|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pa. b. COUNTY ✓ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson | | c. LENGTH OF STAY IN lb | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1780 Joan Ave. | | d. STREET ADDRESS 3062 Hermitage Ave. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | First JAMES | Middle J. | Last HESSION | 4. DATE OF DEATH August 28, 1959. | Month Day Year |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Oct. 3, 1889 | 9. AGE (In years lost birthday) 69 yrs. | 10. IF UNDER 1 YEAR; IF UNDER 24 HRS. Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10b. KIND OF BUSINESS OR INDUSTRY Coal Miner. | | 11. BIRTHPLACE (State or foreign country) Scranton, Pa. | |
| 13. FATHER'S NAME Patrick Hession | | 14. MOTHER'S MAIDEN NAME Unknown. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Elvera M Pohlner 1780 Joan Ave Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 523.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. | | DUE TO (b) DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 24h. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) | | DUE TO | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 21, 1954, to 22, 1954, that I last saw the deceased alive on 22, 1954, and that death occurred at 4:08 P.M. from the causes and on the date stated above. | | | | | |
| ACTUAL SIGNATURE Joseph F. Hession M.D. | | | ADDRESS (Street, city or town, state) Towson, Md. | | |
| PHYSICIAN'S NAME (Type) Joseph F. Hession M.D. | | | DATE SIGNED 1954 | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 8-31-59. | | 22c. NAME OF CEMETERY OR CREMATORIAL ST. JOSEPH'S CEM. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Charles S. Jensen | | ADDRESS 901 S. CONKLING ST. BALTIMORE, MD. | | 24a. REC'D BY REGISTRAR DA SEP 1 '59 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Charles S. Jensen | |



1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08797

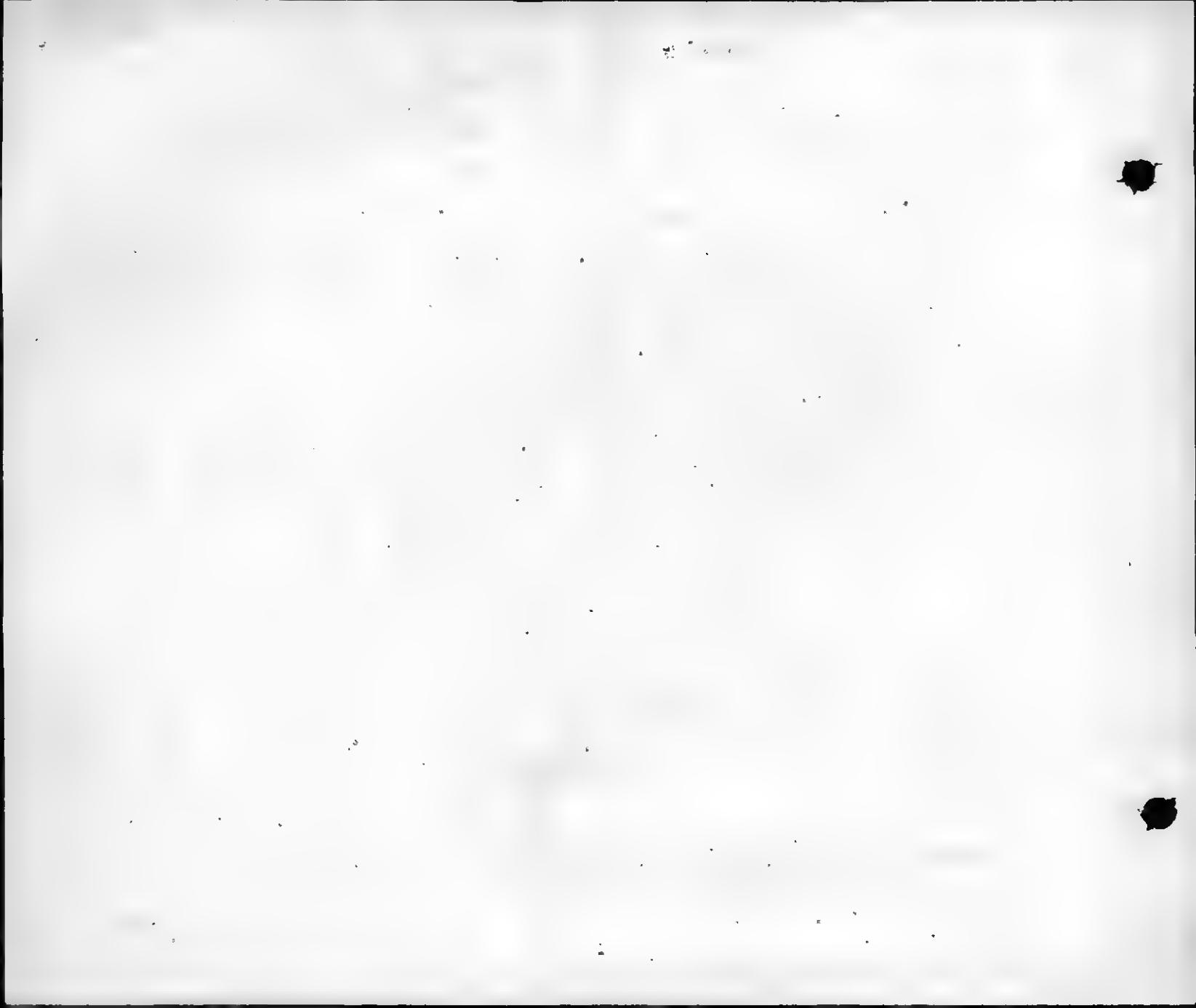
8832 CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE | |
| Baltimore MARYLAND | | Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chase | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Chase | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rt. 16 Box 297 | | d. STREET ADDRESS Rt. 16 Box 297 | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) | | First Homer | Middle H. |
| Last Hicks | | 4. DATE OF DEATH | Month August |
| | | Day 27 | Year 1959 |
| 5. SEX | | 6. COLOR OR RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> |
| Male | | White | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor-Retired | | 10b. KIND OF BUSINESS OR INDUSTRY Dept. Store | 11. BIRTHPLACE (State or foreign country) Tennessee |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | |
| 13. FATHER'S NAME Russell W. Hicks | | 14. MOTHER'S MAIDEN NAME Mary Pass | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 413-09-2241 | INFORMANT Mrs. Earl Steiner |
| | | Address Rt. 16 Box 297 20 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | INTERVAL BETWEEN ONSET AND DEATH Stroke | |
| 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO | | Coronary Occlusion Arteriosclerosis - A.S.D. (c) DUE TO 15 yrs. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION IN PART I(a) Advanced Pulmonary Emphysema | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II, or item 18.) | |
| 20c. TIME OF INJURY Hour a. m. p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>Jan</u> , 1952, to <u>Aug 27</u> , 1959, that I last saw the deceased alive on <u>Aug 10</u> , 1959, and that death occurred at <u>1515 Martin Blvd.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. 1515 Martin Blvd. - 8/28/59 DATE SIGNED | | | |
| ACTUAL INFORMATION PHYSICIAN'S NAME (Type) | | Joseph J. Cameron JOSEPH J. CAMERON Baltimore, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 22b. DATE THEREOF Aug. 28, 1959 | 22c. NAME OF CEMETERY OR CREMATORIAL Westview |
| 22d. LOCATION (City, town, or county) Sweet Water, Tennessee | | (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Lissabon Funeral Home | | ADDRESS 7401 Belair Rd. | 24a. REC'D BY REGISTRAR DATE AUG 31 '59 |
| | | | 24b. REGISTRAR'S SIGNATURE Arthur & Tamm |



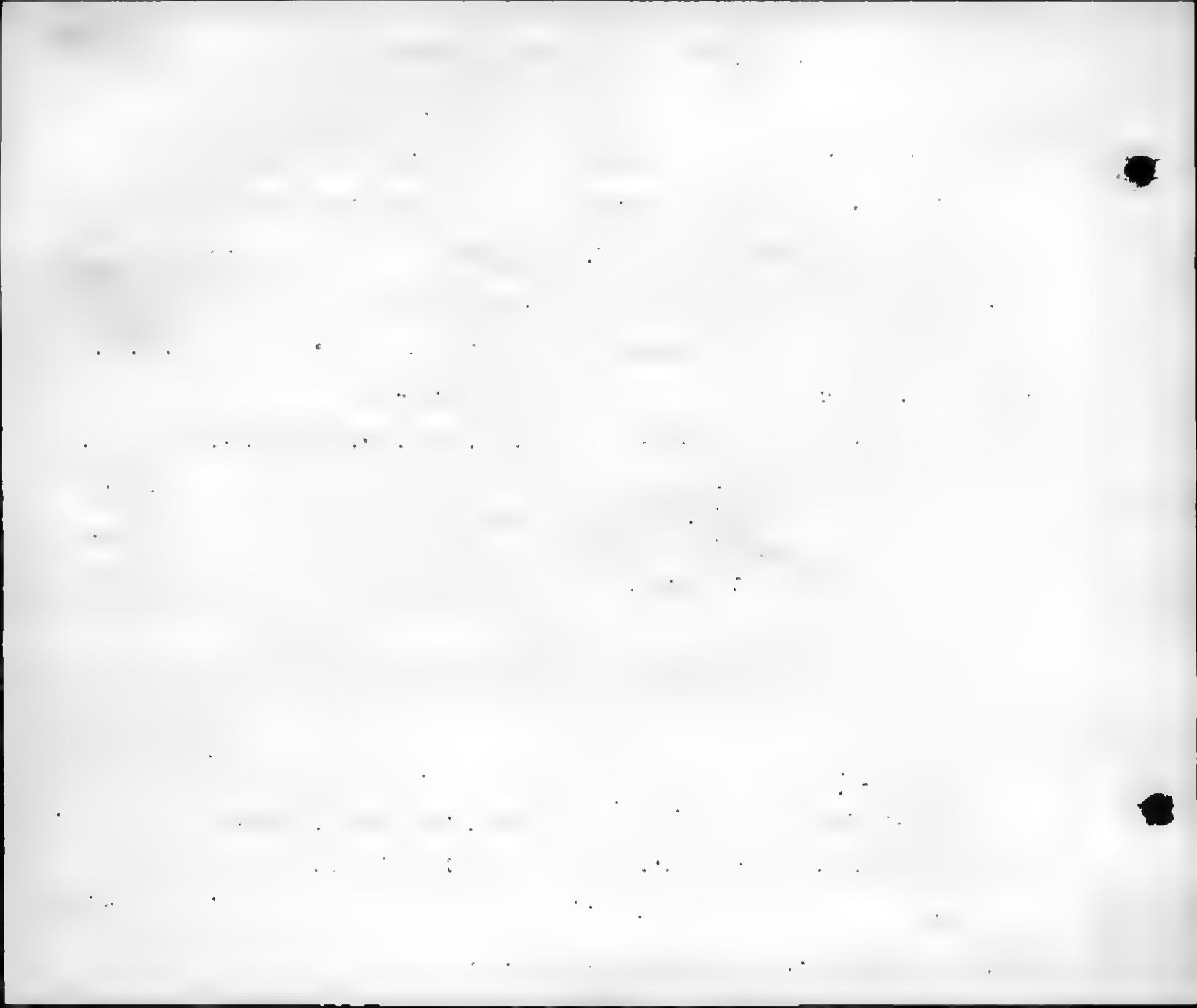
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8833 CERTIFICATE OF DEATH

08798

Reg. Dist. No.

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard | | c. LENGTH OF STAY IN 1b 4 Days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | First AUBREY | Middle G. | Last HOOPER |
| 4. DATE OF DEATH | Month August | Day 5 | Year 1959 |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH January 1, 1916 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Helper | 10b. KIND OF BUSINESS OR INDUSTRY Bakery | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | 12. CITIZEN OF WHAT COUNTRY? U. S. A. |
| 13. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | 16. SOCIAL SECURITY NO. 218-10-6920 | INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md. | Address |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA | | | |
| DUE TO CHRONIC GLOMERULONEPHRITIS | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last (b) PULMONARY EDEMA | | | |
| (c) CARCINOMA, LUNG | | | |
| INTERVAL BETWEEN ONSET AND DEATH RECENT | | | |
| OLD | | | |
| RECENT | | | |
| UNKNOWN | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 20d. INJURY OCCURRED p. m. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | | | |
| 21. I certify that VA attended the deceased from August 1, 1959 , to August 5, 1959 , and that death occurred at 11:15 AM from the causes and on the date stated above. | | | |
| ADDRESS (Street, city or town, state) | | | |
| DATE SIGNED 8/6/59 | | | |
| ACTUAL SIGNATURE <i>John W. Crawford</i> | M.D. VAH, FORT HOWARD, MARYLAND | | |
| PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, M.D. | VAH, FORT HOWARD, MARYLAND | | |
| 22a. BURIAL, CREMATION REMOVAL (Specify) Burial | 22b. DATE THEREOF 8-10-59 | 22c. NAME OF CEMETERY OR CREMATORIUM Meadowridge Cemetery | 22d. LOCATION (City, town or county) Washington Blvd., Balto. Maryland |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm Cook - Blight Inc.</i> | ADDRESS 6009 Harford Rd., Balto. Md. | 24a. REC'D BY REGISTRAR AUG 10 '59 | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Trahan</i> |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8834

CERTIFICATE OF DEATH

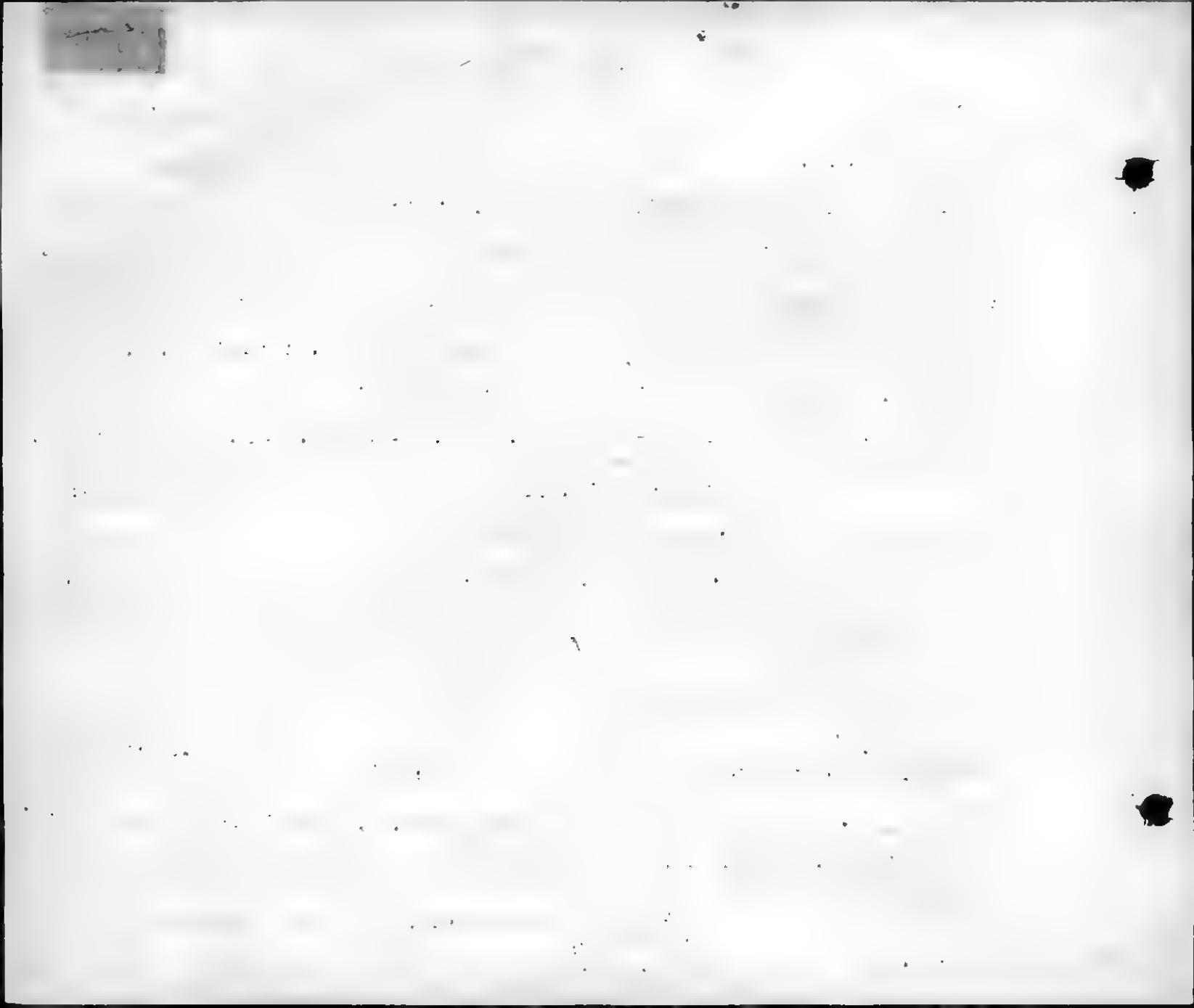
08799

Reg. Dist. No.

| | | | | | | | |
|--|-----------------------------|--|--|---|--|--|----------------------------------|
| 1. PLACE OF DEATH a. COUNTY Baltimore | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland | | b. COUNTY Anne Arundel | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Md. | | c. LENGTH OF STAY IN 1b 110 Days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie | | d. STREET ADDRESS Rt. #1, Box 98 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) | First IRVING | Middle LEE | Last HOWARD | 4. DATE OF DEATH | Month August | Day 24 | Year 1959 |
| 5. SEX Male | 6. COLOR OR RACE Colored | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH August 9, 1893 | 9. AGE (In years last birthday) 66 | 10. IF UNDER 1 YEAR Months 0 | 11. IF UNDER 24 HRS Days 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stevedore | | 10b. KIND OF BUSINESS OR INDUSTRY Loading Cargo | | 11. BIRTHPLACE (State or foreign country) Anne Arundel Co., Maryland | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Elijah G. Howard | | 14. MOTHER'S MAIDEN NAME Sarah Carroll | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes <input type="checkbox"/> or unknown) Yes | | 16. SOCIAL SECURITY NO 215-05-5926 | | INFORMANT Clin. Records, VAH, Balto. 18, Md., Fort Howard Div. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] | | | | | | | |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1.22.1 DUE TO Convulsive Seizure | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last (b) DUE TO Cardiovascular Accident | | | | | | | |
| DUE TO (c) GENERALIZED ARTERIOSCLEROSIS | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| Pneumonia | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Hour a. m. p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that <u>VA</u> attended the deceased from <u>May 6</u> , 1959, to <u>August 21</u> , 1959, and that death occurred at 10:10 AM , and that death occurred at <u>10:10 AM</u> , from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) | | | | | |
| ACTUAL SIGNATURE <u>James R. Powder</u> | | DATE SIGNED 8/21/59 | | | | | |
| PHYSICIAN'S NAME (Type) JAMES R. POWDER, M.D. | | M.D. VAH, BALTO. MD., FORT HOWARD DIVISION | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 8-27-59 | | 22c. NAME OF CEMETERY OR CREMATORIAL Baltimore National Cem. | | 22d. LOCATION (City, town, or county) Baltimore, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Elroy Wilson | | ADDRESS 601 Hamburg, Balto., Md. | | 24a. REC'D BY REGISTRAR DATE SEP 8 '59 | | 24b. REG STRR'S SIGNATURE Charles & Krause | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

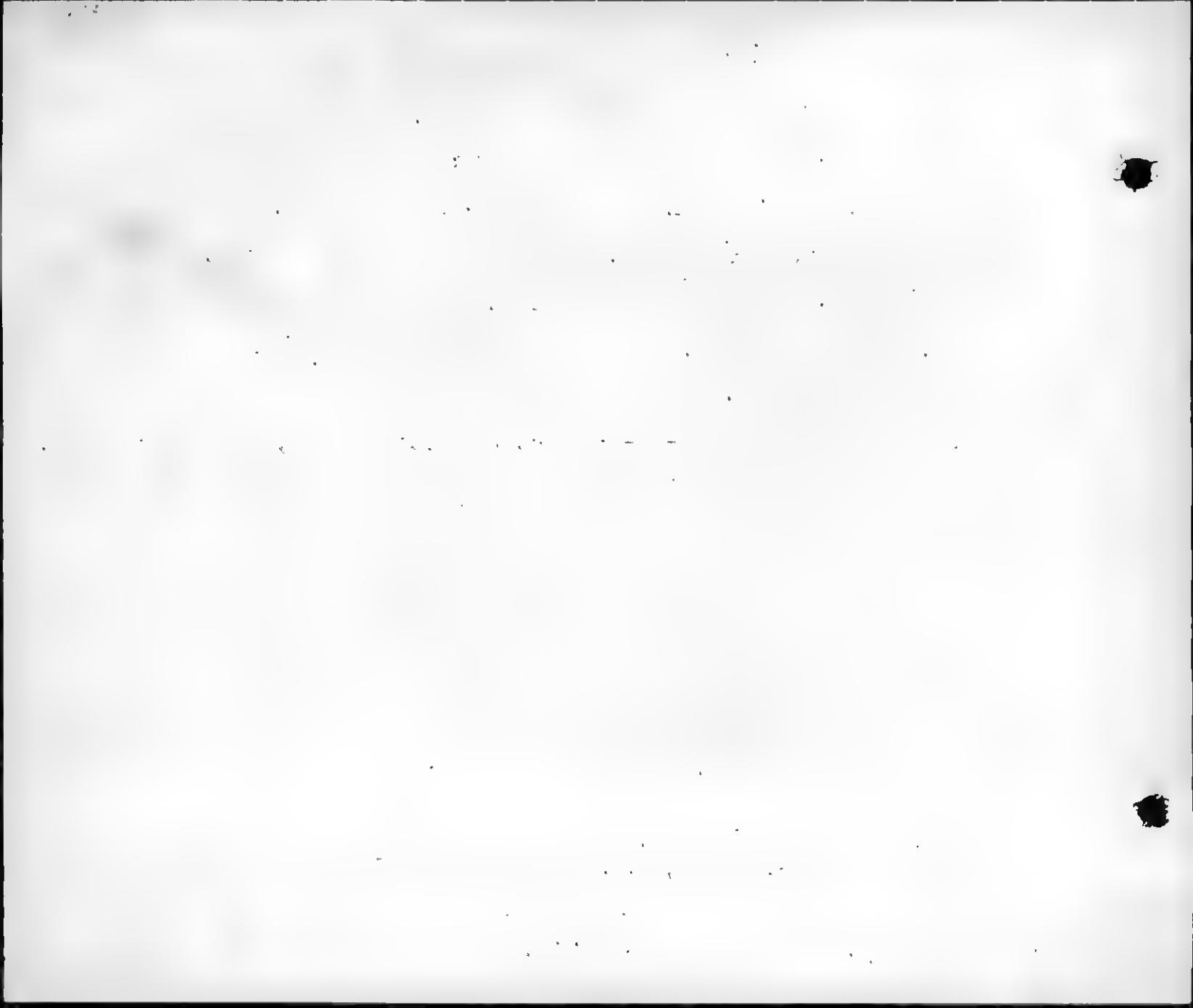
8835

CERTIFICATE OF DEATH

08800

Reg. Dist. No.

| | | | |
|--|--|--|---|
| 1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md.</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i> | | c. LENGTH OF STAY IN 1b <i></i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>3012 Taylor Ave.</i> | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i> | |
| 3. NAME OF DECEASED (Type or print) <i>Conrad</i> | | First <i>H.</i> | Middle <i>Huether</i> |
| 4. DATE OF DEATH <i>Aug. 15 1959</i> | | Month <i>Aug.</i> | Day <i>15</i> |
| 5. SEX <i>male</i> | | 6. COLOR OR RACE <i>white</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <i></i> |
| 8. DATE OF BIRTH <i>Feb. 8, 1879</i> | | 9. AGE (in years last birthday) <i>80</i> | 10. IF UNDER 1 YEAR Months <i></i> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ret. Sherwood Oil Co.</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i></i> | 11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i> |
| 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 13. FATHER'S NAME <i>Louis Huether, Sr.</i> | |
| 14. MOTHER'S MAIDEN NAME <i></i> | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> | |
| 16. SOCIAL SECURITY NO. <i>212-18-8500</i> | | 17. EMPLOYMENT <i>Mr. Douglas Huether, 6008 Roland Ave.</i> | Address <i></i> |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). <i>420.0</i> | | INTERVAL BETWEEN ONSET AND DEATH <i>3 years</i> | |
| DUE TO <i>ARTERIOSCLEROTIC HEART DISEASE</i> | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <i></i> | | | |
| DUE TO (c) <i></i> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION IN PART I(a) | | 19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour a. m. p. m. <i>19</i> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <i></i> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i> |
| 20f. (City or town) <i></i> | | (County) <i></i> | |
| (State) <i></i> | | | |
| 21. I certify that I attended the deceased from <i>3 August 1959</i> to <i>15 August 1959</i> , that I last saw the deceased alive on <i>13 Aug.</i> , 19 <i>59</i> and that death occurred at <i>7 A.M.</i> from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) <i></i> | |
| ACTUAL SIGNATURE <i>John B. DeHoff, M.D.</i> | | DATE SIGNED <i></i> | |
| PHYSICIAN'S NAME (Type) <i>John B. DeHoff, M.D.</i> | | Loch Raven Shopping Center | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 22b. DATE THEREOF <i>8/18/59</i> | 22c. NAME OF CEMETERY OR CREMATORIAL <i>Baltimore Cemetery</i> |
| 22d. LOCATION (City, town, or county) <i>Baltimore, Maryland</i> | | (State) <i></i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i> | | 24a. ADDRESS <i>5305 Harford Rd.</i> | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i> |
| DATE <i>AUG 18 '59</i> | | 24c. REC'D BY REGISTRAR <i></i> | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8836

CERTIFICATE OF DEATH

08801

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY

Baltimore

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Overlea

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

701 Old Home Rd.

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)

b. STATE

Maryland

b. COUNTY

Baltimore

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Overlea

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

Month

Day

Year

5. SEX

6. COLOR OR RACE

Male White

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

March 28, 1906

9. AGE (In years
lost birthday)

53 yrs.

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Lieutenant

10b. KIND OF BUSINESS OR INDUSTRY

Balto. Co. Police

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Columbus Jacques

14. MOTHER'S MAIDEN NAME

Mary Dawson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

(If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

None

17. INFORMANT

Leona A. Jacques

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which

gave rise to immediate

cause (a), stating the under-

lying cause last.

(b)

DUE TO

(c)

Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

NONE

19. WAS AUTOPSY

PERFORMED?

YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year

Hour a. m. 19

p. m.

20d. INJURY OCCURRED

White Not white

of work of work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from

1959, to

Aug. 8, 1959, that I last saw the deceased

alive on

3:15 p.m. 8/8/59

, and that death occurred at

3:30 p.m.

, from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL SIGNATURE

B. D. Smith

M.D.

6900 Harford Rd.

PHYSICIAN'S NAME (Type)

B. D. Smith

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

Aug. 11, 1959

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORI

Gardens of Faith

22d. LOCATION (City, town, or county)

Balto. Co. Md.

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

Lassahn Funeral Home

7401 Belair Rd.

ADDRESS

24a. REC'D BY REGISTRAR

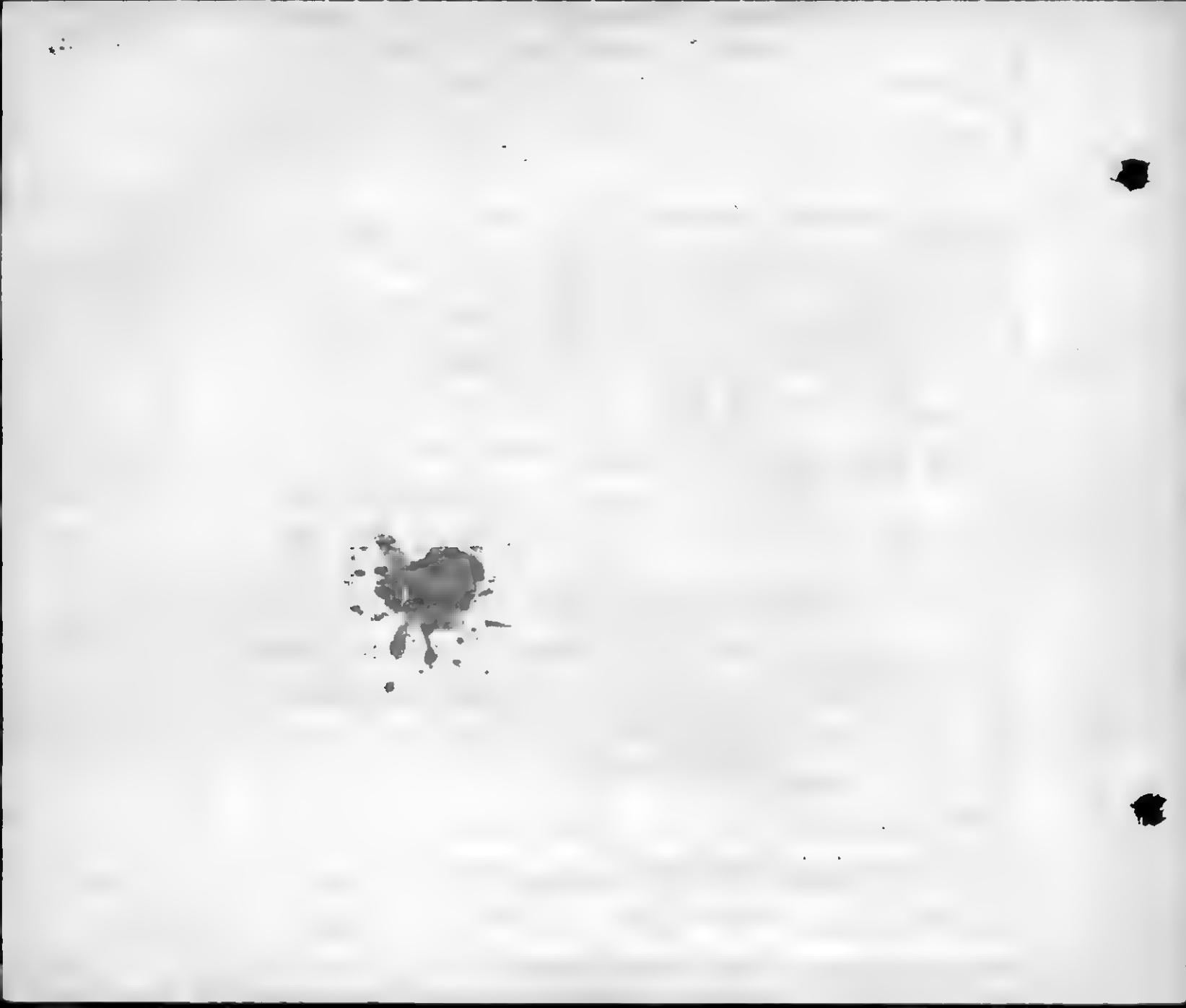
Aug. 11, 1959

DATE

24b. REGISTRAR'S SIGNATURE

Charles S. Kraus

Signature



TO HOSPITAL OR ENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

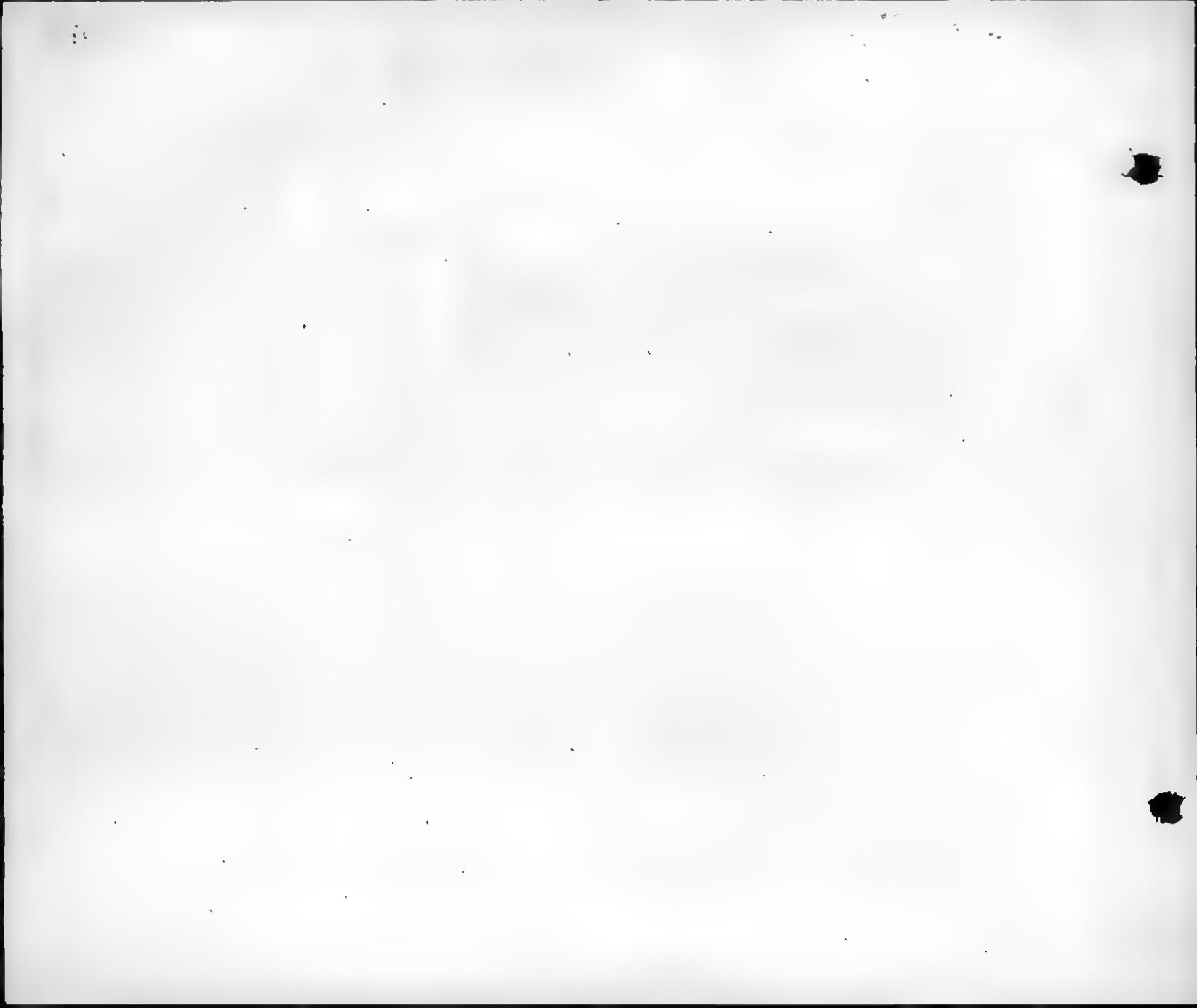
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8837 CERTIFICATE OF DEATH

Reg. Dist. No. 08802

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MD</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i> | | c. LENGTH OF STAY IN 1b <i>70 yr</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Housin Pines 16 Fostling Ave</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore 34</i> | |
| d. STREET ADDRESS <i>1612 Colman St</i> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | First <i>Anna</i> | Middle <i>Jones</i> | 4. DATE OF DEATH <i>Aug. 2 1959</i> |
| 5. SEX <i>Female</i> | 6. COLOR OR RACE <i>W</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>Mar. 9, 1885</i> |
| 9. AGE (In years, last birthday) <i>74 yrs</i> | 10. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> | 11. IF UNDER 24 HRS Hours <i>0</i> Min. <i>0</i> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Petred Saleslady</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Hochschild Kohn</i> | |
| 11. BIRTHPLACE (State or foreign country) <i>Worchester 60, Md.</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i> | |
| 13. FATHER'S NAME <i>Let James Cleane</i> | | 14. MOTHER'S MAIDEN NAME <i>Emma</i> | |
| 15. WAS DECEASED EVER IN J. S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i> | | 16. SOCIAL SECURITY NO. <i>Miss Dorothy Jones 1016-74-00000000</i> | |
| 17. INFORMANT <i>Miss Dorothy Jones 1016-74-00000000</i> | | Address <i>1016-74-00000000</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> | | | |
| DUE TO <i>331X</i> | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Generalized arteriosclerosis</i> | | | |
| DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>10-23-1957</i> to <i>8-2-1959</i> , that I last saw the deceased alive on <i>8-1-1959</i> , and that death occurred at <i>1016-74-00000000</i> M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>Wilmer K. Gallagher</i> | | ADDRESS (Street, city or town, state) <i>6209 Frederick Ave.</i> | |
| PHYSICIAN'S NAME (Type) <i>Wilmer K. Gallagher</i> | | DATE SIGNED <i>8-3-59</i> | |
| 22a. BURIAL, CREMATION OR REMOVAL (Specify) <i>Burial Aug 4 1959</i> | | 22b. DATE THEREOF <i>Aug 4 1959</i> | |
| 22c. NAME OF CEMETERY OR CREMATORY <i>Greenmount</i> | | 22d. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur E. Edmonson</i> | | 24a. REC'D BY REGISTRAR DATE <i>AUG 4 '59</i> | |
| ADDRESS <i>See</i> | | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i> | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

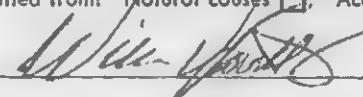
8838

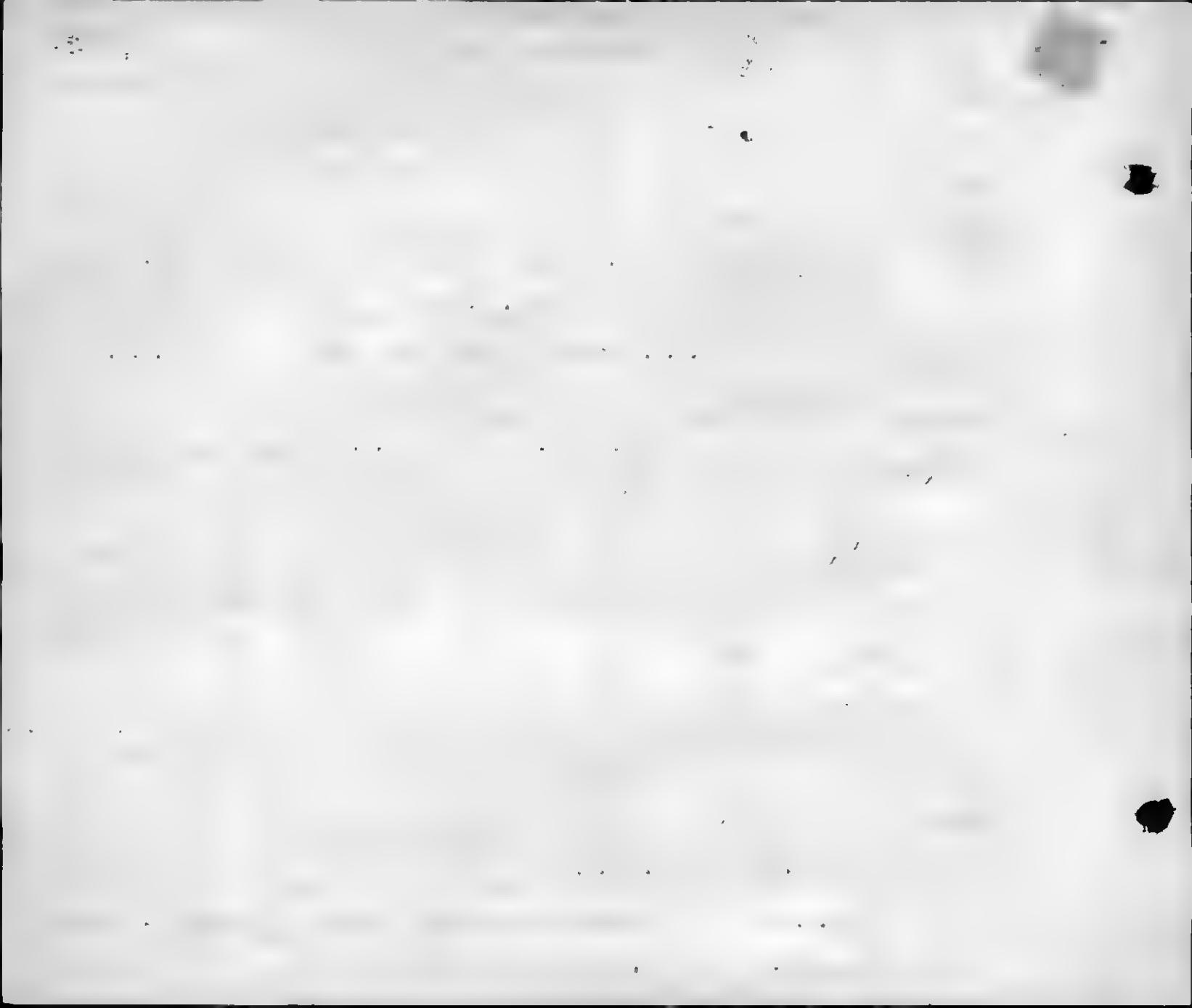
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

108803

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

| | | | | | | | | |
|--|------------------|---|------------------|---|----------------------------|---|------------|--------------|
| 1. PLACE OF DEATH a. COUNTY | | Item 20b, Film G-246 8/12/59 Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) | | Reg. Dist. No. | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. LENGTH OF STAY IN lb | | d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | b. COUNTY | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | 1407 Eastern Avenue | | d. STREET ADDRESS | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) | | First JOSEPH | Middle J. | Last JANS | 4. DATE OF DEATH | Month August | Day 3, | Year 1959 |
| 5. SEX | 6. COLOR OR RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | B. DATE OF BIRTH | 9. AGE (In years last birthday) 19 yrs. | IF UNDER 16 YRS. Months | IF UNDER 24 HRS. Days | Hours Min. | |
| Male | White | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | Apr. 10, 1940 | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | | |
| Seaman | | U.S.S. Cadmus | | Waverly, Iowa | | U.S.A. | | |
| 13. FATHER'S NAME Dick Jans | | | | 14. MOTHER'S MAIDEN NAME Mildred (Unknown) | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | |
| | | Unknown | | Mr. Dick Jans R.R.#2 Delwin, Iowa | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | | | | | | |
| PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Drowning X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ | | | | | | | | |
| DUE TO DUE TO (c) _____ | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell overboard from ghost ship Boat | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour 8 a.m. 3:30 p.m. 8/2/1959 | | 20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) Off Breezy Point, Middle River, Balto. Co., Md. | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | | | | | | |
| ACTUAL SIGNATURE  | | DATE SIGNED 8/4/59 | | | | | | |
| EXAMINER'S NAME (Type) | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 22b. DATE THEREOF Aug. 6, 1959 | | 22c. NAME OF CEMETERY OR CREMATORIAL Immaculate Conception | | 22d. LOCATION (City, town, or county) Fairbanks (Fayette Co.) Iowa (State) | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc. | | ADDRESS 1217 St. Paul Street | | 24a. REC'D BY REGISTRAR DATE AUG 10 '59 | | 24b. REGISTRAR'S SIGNATURE  | | |

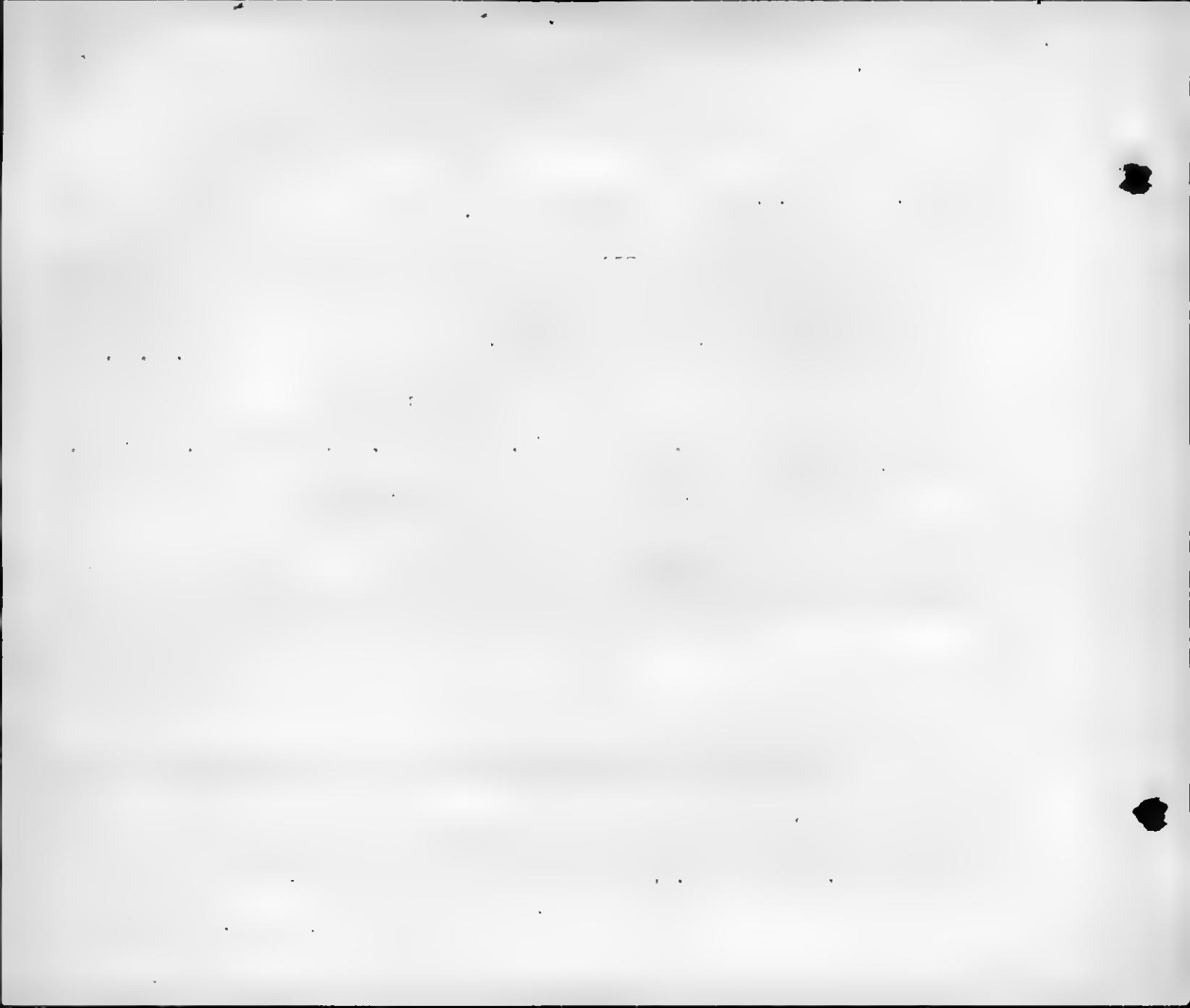


MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8839
CERTIFICATE OF DEATH

08804

Reg. Dist. No.

| | | | | | | | | | | |
|---|--|---|---|--|--|---|--|-----------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland | | b. COUNTY | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard | | c. LENGTH OF STAY IN lb 1 Day | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | | d. STREET ADDRESS 511 W. Hoffman Street (1) | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | |
| 3. NAME OF DECEASED (Type or print) First ELLIOTT | | Middle --- | | Lost JOHNSON | | 4. DATE OF DEATH August 13 | Month August | Doy 13 | Year 1959 | |
| 5. SEX Male | | 6. COLOR OR RACE Colored | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH August 15, 1893 | | 9. AGE (In years last birthday) 65 yrs. | 10. IF UNDER 1 YEAR Months 0 Days 0 | | 11. IF UNDER 24 HRS Hours 0 Min. 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook | | 10b. KIND OF BUSINESS OR INDUSTRY Railroad | | 11. BIRTHPLACE (State or foreign country) Union South Carolina | | 12. CITIZEN OF WHAT COUNTRY U. S. A. | | | | |
| 13. FATHER'S NAME Dan Johnson | | 14. MOTHER'S MAIDEN NAME Fannie MN: Unknown | | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) Yes | | 16. SOCIAL SECURITY NO Unk. | | 17. INFORMANT Clin. Records, Vet. Adm. Hospital, Ft. Howard, Md. | | Address | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ✓ Cerebral Hemorrhage | | CEREBRAL HEMORRHAGE, RIGHT CEREBRUM | | | | INTERVAL BETWEEN ONSET AND DEATH 5 days | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. ✓ Bronchogenic carcinoma right lung | | BRONCHGENIC CARCINOMA RIGHT LUNG | | | | 1½ years | | | | |
| | | BRONCHOPNEUMONIA | | | | 2 days | | | | |
| | | ARTERIOSCLEROTIC HEART DISEASE | | | | unknown | | | | |
| | | ANEURYSM, THORACIC AORTA | | | | unknown | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. VA | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.) | | 20f. (City or town) VA | | (County) VA | (State) VA | |
| 21. I certify that I attended the deceased from August 12, 1959 to August 13, 1959 and that death occurred at 6:20 P.M. from the causes and on the date stated above | | | | | | ADDRESS (Street, city or town, state) | | | | |
| ACTUAL SIGNATURE John W. Crawford | | M.D. VAH, FORT HOWARD, MARYLAND | | | | DATE SIGNED 8/14/59 | | | | |
| PHYSICIAN'S NAME (Type) John W. Crawford, M.D. | | VAH, FORT HOWARD, MARYLAND | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 8/19/59 | | 22c. NAME OF CEMETERY OR CREMATORIAL Baltimore National Cemetery | | 22d. LOCATION (City, town, or county) Baltimore, Maryland | | (State) | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Arlington Phillips, 1808 N. Monroe St. | | ADDRESS Baltimore, Md. 21217 | | 24a. REC'D BY REGISTRAR DA 1749 | | 24b. REGISTRAR'S SIGNATURE R. Thomas | | | | |



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PK3. Page 5 may be retained for reference. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-trust permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18-21 Film 48-18840 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

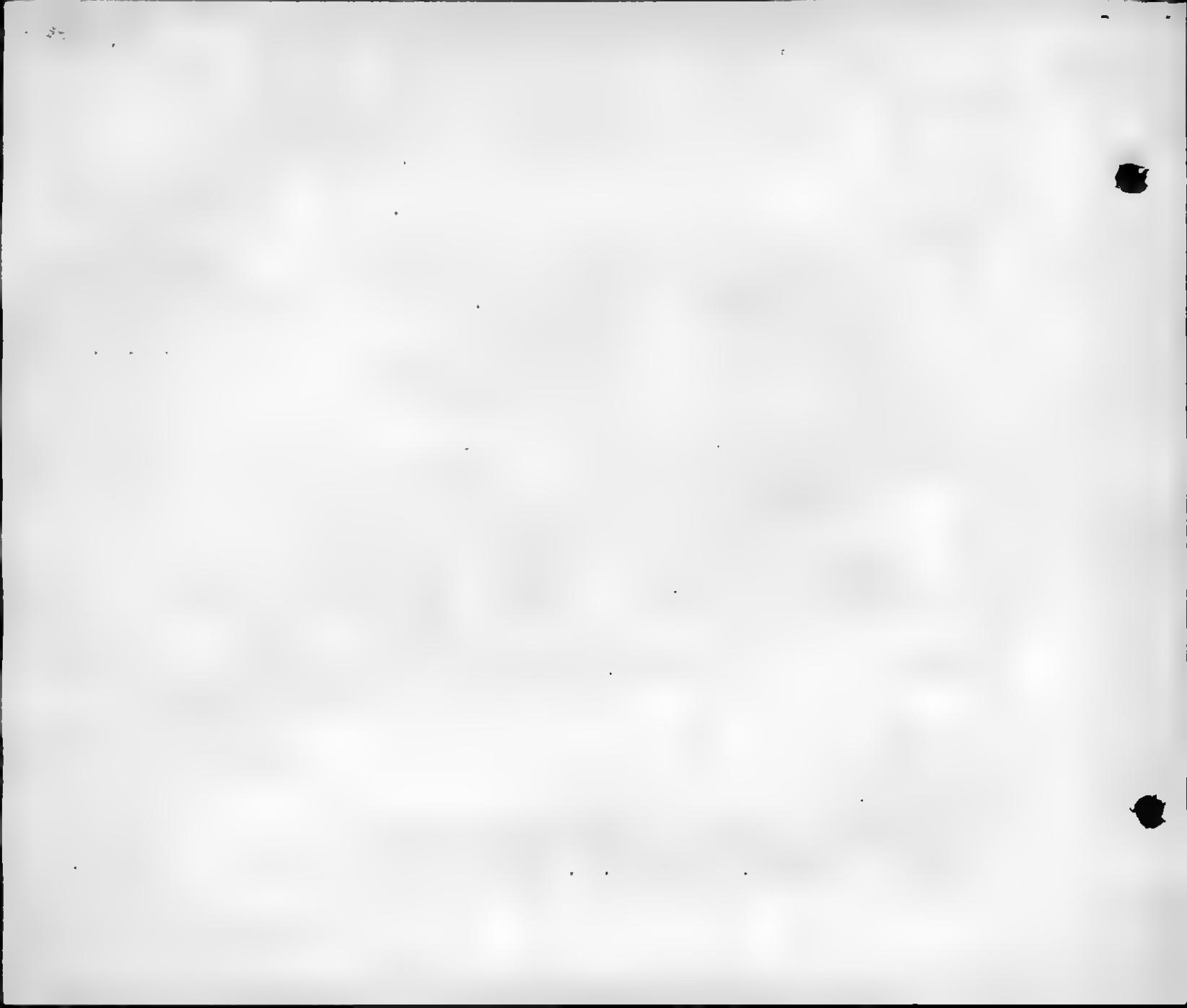
8840

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08805

Reg. Dist. No.

| | | | | | |
|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY | | Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. LENGTH OF STAY (In lb) | | a. STATE Maryland b. COUNTY | |
| Catonsville | | 4 days | | Baltimore 25 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | d. STREET ADDRESS | | e. IS RE BURIED ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| SPRING GROVE STATE HOSPITAL | | 3713 St. Margaret Street | | | |
| 3. NAME OF DECEASED (Type or print) | | First Virginia | Middle Louise | Lost Johnson | 4. DATE OF DEATH Month August Day 11 Year 1959 |
| 5. SEX | | 6. COLOR OR RACE female white | 7. MARRIED WIDOWED <input type="checkbox"/> | NEVER MARRIED DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Jan. 11, 1921 |
| 9. AGE (In years from birthday) 38 yrs | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | | |
| 13. FATHER'S NAME Stephen Harrison | | 14. MOTHER'S MAIDEN NAME Nellie Fields | | Address | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown | | 16. SOCIAL SECURITY NO. Unknown | | 17. INFORMANT Records: SPRING GROVE STATE HOSPITAL | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] | | 19. INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 193.0 | | Can gestive heart failure | | | |
| DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | (b) Intracerebral pressure | | | |
| DUE TO | | Encephalomalacia of left cerebral peduncle and (c) temporal tip due to trauma Brain Glioma temporal lobe | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) | | History of fall on street at any time at all; last fall occurred within last ten days | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. unknown | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.) 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | DATE SIGNED 8-12-59 | | | |
| ACTUAL SIGNATURE <i>George M. Kieffer</i> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) George M. Kieffer, M. D. | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 8-15-59 | | 22c. NAME OF CEMETERY OR CREMATORIUM Meadowridge Cemetery | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul Street | | ADDRESS | | 24a. REC'D BY REGISTRAR DATE AUG 13 '59 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Clyde S. Krause | |

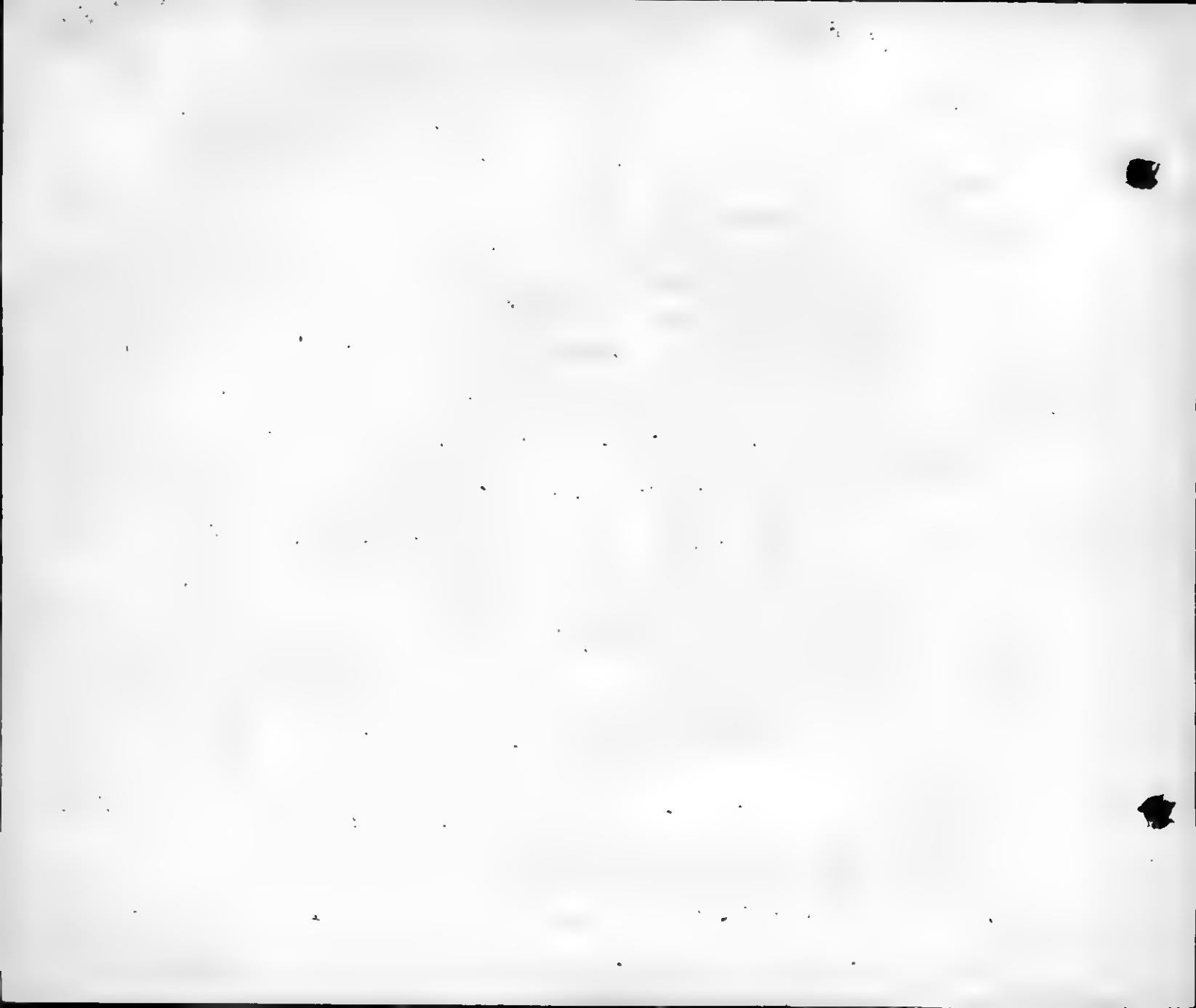


TO HOSPITAL **ENDING PHYSICIAN**: The law requires that the death certificate be executed within 24 hours of death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 8841 CERTIFICATE OF DEATH

Reg. Dist. No. 108806

| | | | | | | | | | | | | | | | |
|--|--|--|---|--|--|--|-----|---|--|---|--|------------------------|--|-----------------------|--|
| 1. PLACE OF DEATH a. COUNTY BALTIMORE | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND | | b. COUNTY BALTIMORE | | | | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE MANOR | | c. LENGTH OF STAY IN 1b 10 yrs. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE MANOR | | d. STREET ADDRESS 5921 Montgomery St. | | | | | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5921 Montgomery St. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) JAMES LOUIS | | First | Middle | Last | 4. DATE OF DEATH JONES | Month | Day | Year | | | | | | | |
| 5. SEX MALE | | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH Feb. 15, 1887 | 9. AGE (In years last birthday) 72 yrs. | 10. UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0 | | | | | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PACKER | | 10b. KIND OF BUSINESS OR INDUSTRY Dry Goods | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | | | |
| 13. FATHER'S NAME Unknown | | 14. MOTHER'S MAIDEN NAME GRACE JONES | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. 216-01-5694 | | | | | | | | | |
| 17. INFORMANT Margaret Jones | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. DUE TO (b) DUE TO (c) | | 19. INTERVAL BETWEEN ONSET AND DEATH 1 day | | | | | | | | | | | |
| 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute Viral hepatitis | | 21. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) While at work | | 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) London Park | | 20f. (City or town) Baltimore | | (County) Md. | | (State) Md. | |
| 21. I certify that I attended the deceased from alive on 8/7 , 19 59 , and that death occurred at 11:25 PM , from the causes and on the date stated above. | | 22. ACTUAL SIGNATURE Edward S. Wallace | | 23. PHYSICIAN'S NAME (Type) Edward S. Wallace | | 24. ADDRESS (Street, city or town, state) 9300 Liberty He Bz | | 25. DATE SIGNED 8/8/59 | | | | | | | |
| 22a. BUR. AL. CREMATION, REMOVAL Burial | | 22b. DATE THEREOF Aug. 11, 1959 | | 22c. NAME OF CEMETERY OR CREMATORIAL London Park | | 22d. LOCATION (City, town, or county) Baltimore | | (State) Md. | | | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE GEO. L. Schwab, FUNERAL Francis H. Miller | | 24. ADDRESS 2101 Frederick Ave. | | 24a. REC'D BY REGISTRAR Aug 11 '59 | | 24b. REGISTRAR'S SIGNATURE John S. Evans | | | | | | | | | |



X 1 X
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PK3. Page 5 may be retained by your files.

TO FUNERAL DIRECTOR: Page 3 should be given to a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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8842 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
Item 4, Film Q-253 12, 23/59, c.c.

08807

Reg. Dist. No.

| | |
|---|--|
| 1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> | 2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <i>Md</i> |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Anneslie</i> | b. COUNTY <i>Baltimore</i> |
| c. LENGTH OF STAY IN 1b <i>few hours</i> | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i> |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>508 Overbrook Road</i> | d. STREET ADDRESS <i>116 W University Pky</i> |
| e. IS RELATIVES ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 4. DATE OF DEATH Month Day Year <i>Aug 19, 1959</i> |
| 3. NAME OF DECEASED (Type or print) <i>Roland Hall Jones</i> | 5. SEX <i>Male</i> |
| 6. COLOR OR RACE <i>White</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> <i>Feb 3/1882</i> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>retired</i> | 10b. KIND OF BUSINESS OR INDUSTRY <i>Tailor</i> |
| 11. BIRTHPLACE (State or foreign country) <i>Nijensie</i> | 9. AGE (In years last birthday) <i>77 yrs</i> |
| 12. CITIZEN OF WHAT COUNTRY? <i>E.S.</i> | 10. IF UNDER 18 YEARS Months Days Hours Min. <i>8 15 00</i> |
| 13. FATHER'S NAME <i>John W Jones</i> | 14. MOTHER'S MARRIED NAME <i>Ellen Parker</i> |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war number or ser. no.) <i>No</i> | 16. SOCIAL SECURITY NO. <i>25-03-4444</i> |
| 17. INFORMANT <i>W. H. Medill</i> | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral hemorrhage</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio sclerosis, generalized DUE TO (c) 10 yrs |

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY or CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 20)

20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19

20d. INJURY OCCURRED While of work Not while of work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion death resulted from: Natural causes Accident , Suicide , Homicide , Undetermined manner

ACTUAL
SIGNATURE

Dirk Van Peenan

M.D. CHIEF MEDICAL EXAMINER

DATE SIGNED
8/10/59

EXAMINER'S
NAME (Type)

Dirk Van Peenan, M.D.

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

22a. BURIAL, CREMATION, ETC. DATE THEREOF
REMOVAL (Specify)

22c. NAME OF CEMETERY OR CREMATORIUM
General Cemetery

22d. LOCATION (City, town, or county)
Baltimore

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

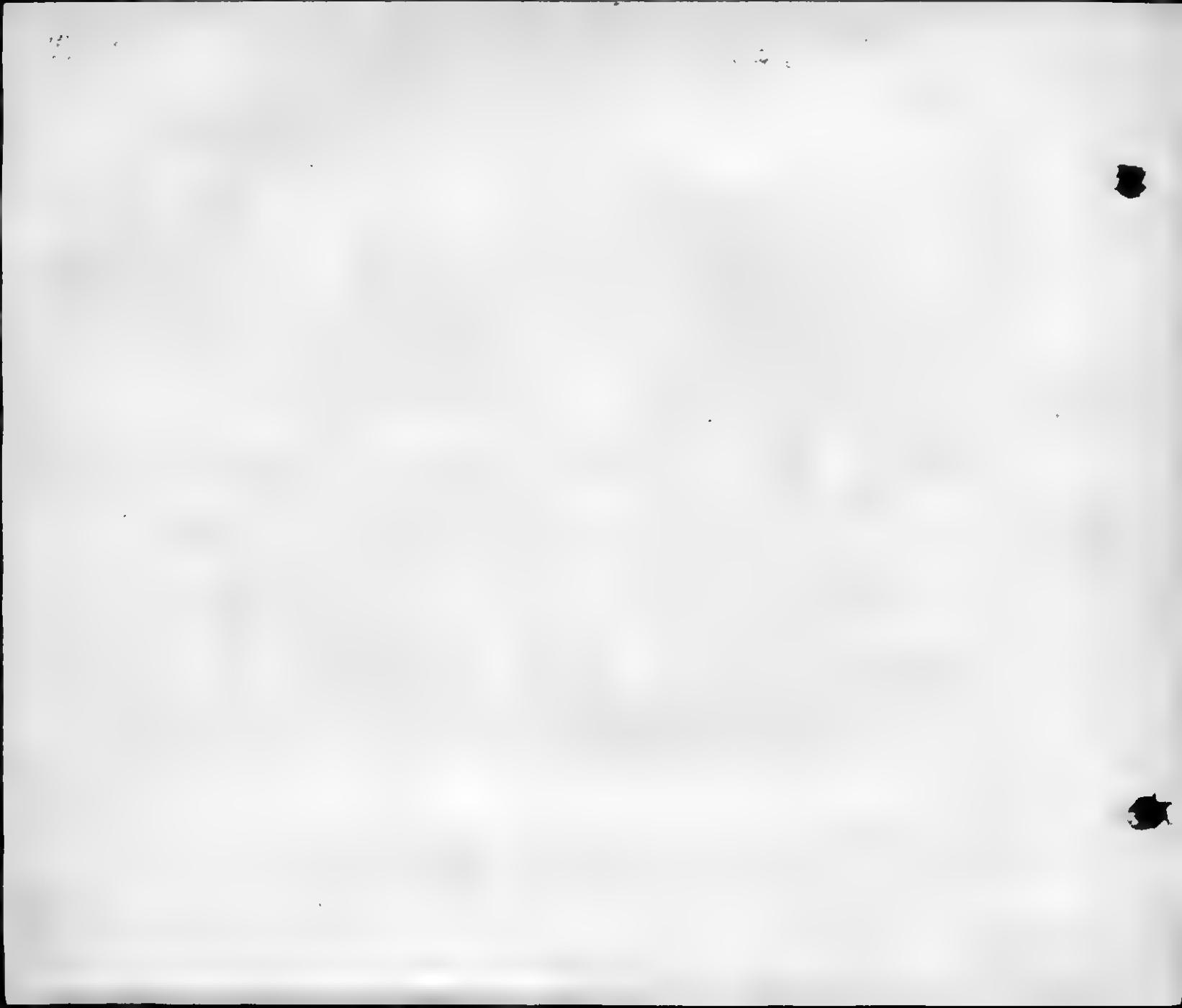
24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

Edward Morris 108 W York St-1

DATE AUG 11 '59

Arthur S. Kline



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8843

CERTIFICATE OF DEATH

08808

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
 15M 10/57

| | | | | | | | | |
|---|--|--|---|---|---|--|-------------------------|------------------------|
| 1. PLACE OF DEATH a. COUNTY Balto. | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. | | b. COUNTY Balto. | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson | | c. LENGTH OF STAY IN 1b RURAL | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson | | d. STREET ADDRESS 417 Chestnut Ave. | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 417 Chestnut Ave. | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print) AIMEE W. | | First | Middle | Lost | 4. DATE OF DEATH Aug. 18, 1959 | Month | Day | Year |
| 5. SEX female | | 6. COLOR OR RACE white | 7. MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Feb. 15, 1875 | 9. AGE (In years last birthday) 84 yrs | IF UNDER 1 YEAR Months | IF UNDER 24 HRS Days | Hours |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY retired | | 11. BIRTHPLACE (State or foreign country) Virginia | | 12. CITIZEN OF WHAT COUNTRY? | | |
| 13. FATHER'S NAME William R. Will | | 14. MOTHER'S MAIDEN NAME Mildred Sinclair | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mr. Harold R. Manakes - 417 Chestnut Ave. | | Address | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 | | DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause if any. (b) | | INTERVAL BETWEEN ONSET AND DEATH <i>Arterosclerosis, generalized</i> | | | | |
| DUE TO (c) | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | |
| 20c. TIME OF INJURY Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED White at work <input type="checkbox"/> of work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 401 | | 20f. (City or town) Baltimore | | (County) Md. |
| 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | (State) Md. |
| 20g. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | | | | | |
| 21. I certify that I attended the deceased from April 18, 1951 to Aug. 18, 1959 that I last saw the deceased alive on Aug. 18, 1959 and that death occurred at 6:30 A.M. from the causes and on the date stated above. | | | | | | | | |
| ACTUAL William G. Helfrich, M.D. | | | | ADDRESS (Street, city or town, state) 6006 Roland Ave Baltimore, Md. | | DATE SIGNED 8/19/59 | | |
| PHYSICIAN'S NAME (Type) | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 8/20/59 | | 22c. NAME OF CEMETERY OR CREMATORIAL Loudon Park Cem. | | 22d. LOCATION (City, town, or county) Baltimore, Md. | | (State) |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>John F. Luckett Jr. Esq. - 111</i> | | ADDRESS <i>1727</i> | | 24a. REC'D BY REGISTRAR DATE AUG 20 '59 | | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i> | | |



TO HOSPITAL OR PENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8844

CERTIFICATE OF DEATH

08809

Reg. Dist. No.

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY BALTIMORE | | 2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE MARYLAND | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE | | c. LENGTH OF STAY IN 1b 24 YEARS | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSP. | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE | |
| 3. NAME OF DECEASED (Type or print) DIMITRI | | d. STREET ADDRESS 1409 E. CLEMENT ST. | |
| 3. NAME OF DECEASED (Type or print) DIMITRI | | First KALOTA | Middle KALOTA |
| 3. NAME OF DECEASED (Type or print) DIMITRI | | Last KALOTA | 4. DATE OF DEATH AUGUST 30 1959 |
| 5. SEX MALE | | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 8. DATE OF BIRTH 6/6/1885 | | 9. AGE (In years last birthday) 74 yr | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) JANITOR | | 10b. KIND OF BUSINESS OR INDUSTRY BALTO. & OHIO R.R. | |
| 11. BIRTHPLACE (State or foreign country) BULGARIA | | 12. CITIZEN OF WHAT COUNTRY BULGARIA | |
| 13. FATHER'S NAME (UNKNOWN) | | 14. MOTHER'S MAIDEN NAME KALOTA | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO UNKNOWN | |
| 17. INFORMANT RECORDS OF Address SPRING G. S. Hosp. | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE DUE TO 42 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) GENERALIZED ARTERIOSCLEROSIS + 14 yrs. INTERVAL BETWEEN ONSET AND DEATH + 10 yrs. | |
| 19. WAS AUTOPSY PERFORMED? NO | | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY Month, Day, Year Hour o. m. 20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from _____, 19____, to 8/30/1959 that I last saw the deceased alive on 8/30/1959, and that death occurred at 6:55 PM, from the causes and on the date stated above ADDRESS (Street, city or town, state) Spring Grove State Hosp. Aug. 30 '59 DATE SIGNED Drake June M.D. | | | |
| ACTUAL SIGNATURE Isadore Tuck, M.D. | | | |
| 22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial 8-1-59 | | 22b. DATE THEREOF 8-1-59 | |
| 22c. NAME OF CEMETERY OR CREMATORIUM Cathedral Cem. | | 22d. LOCATION (City, town, or county) Baltimore (State) Md | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Foley Funeral Home, Edmond, Md. | | 24a. REC'D BY REGISTRAR DATE SEP 2 '59 | |
| 24b. REGISTRAR'S SIGNATURE Cathleen & Krause | | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8845

CERTIFICATE OF DEATH

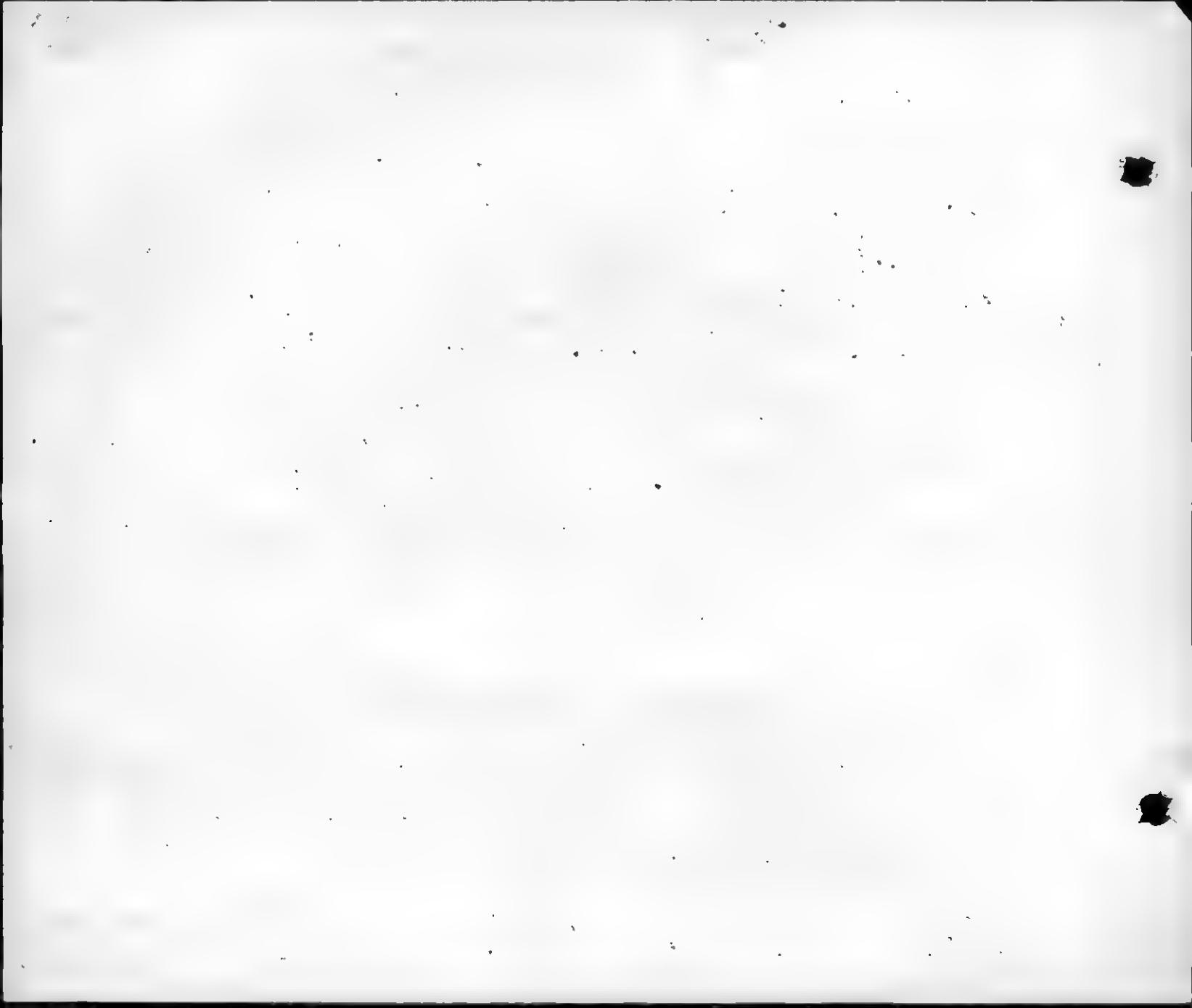
18810

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i> | | c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>3431 Flannery Lane</i> | | d. STREET ADDRESS <i>3431 Flannery Lane</i> | |
| e. NAME OF DECEASED (Type or print) <i>Heyman Kaplan</i> | | First <i>He</i> | Middle <i>man</i> |
| e. NAME OF DECEASED (Type or print) <i>Heyman Kaplan</i> | | Last <i>Kaplan</i> | 4. DATE OF DEATH <i>Aug 5, 1959</i> |
| 5. SEX <i>Male</i> | | 6. COLOR OR RACE <i>White</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 8. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Solomon</i> | | 9. KIND OF BUSINESS OR INDUSTRY <i>Nocahetics</i> | 10. BIRTHPLACE (State or foreign country) <i>Brooklyn, N.Y.</i> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Solomon</i> | | 10b. BIRTHPLACE (State or foreign country) <i>Brooklyn, N.Y.</i> | 11. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> |
| 13. FATHER'S NAME <i>Morris Kaplan</i> | | 14. MOTHER'S MAIDEN NAME <i>Brina</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> | | 16. SOCIAL SECURITY NO <i>None</i> | 17. INFORMANT <i>Mrs. E. C. Kaplan - Same</i> |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] | | 19. INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Infarction</i> | | 1 day | |
| DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) <i>Arteriosclerotic C.V. Disease</i> | | 4 years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>None</i> | | 20. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>None</i> | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <i>Aug 2, 1959</i> to <i>Aug 5, 1959</i> that I last saw the deceased alive on <i>Aug 5, 1959</i> , and that death occurred at <i>7 A.M.</i> from the causes and on the date stated above. | | 22. ADDRESS (Street, city or town, state) <i>4818 Reservoir Rd N.E. - Batt 15 Ma</i> | |
| ACTUAL SIGNATURE <i>Manuel Levin</i> | | DATE SIGNED <i>8/5/59</i> | |
| PHYSICIAN'S NAME (Type) <i>MANUEL LEVIN, M.D.</i> | | M.D. | |
| 22a. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 22b. DATE THEREOF <i>8/6/59</i> | 22c. NAME OF CEMETERY OR CREMATORIUM <i>Beth Tephila</i> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Sol Levinson & Sons Inc</i> | | ADDRESS <i>1120-26 N. Smith Ave</i> | 24a. REC'D BY REGISTRAR <i>AUG 7 '59</i> |
| | | | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i> |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8846 CERTIFICATE OF DEATH

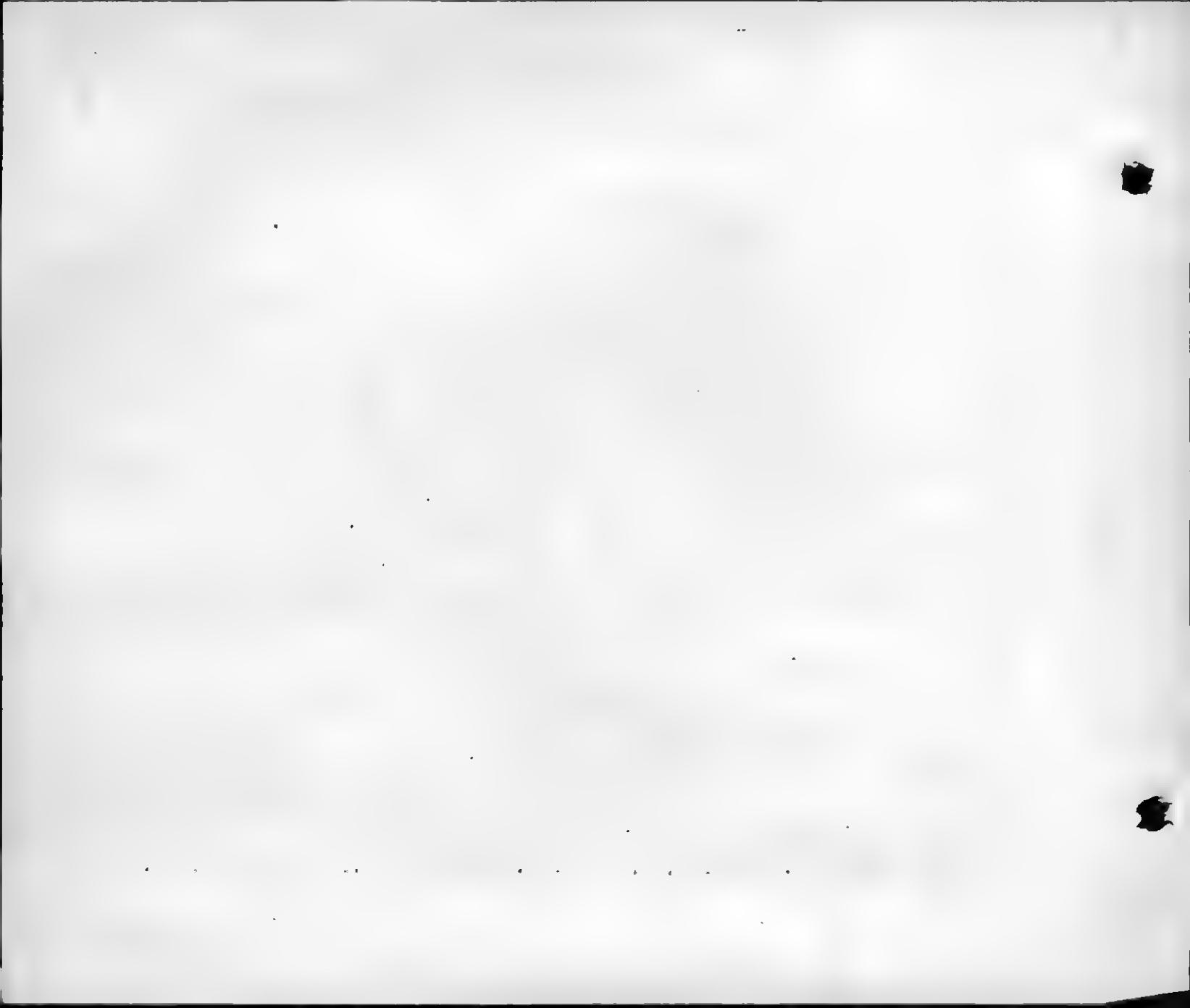
08811

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|---|--|---|----------------------------|
| 1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i> | | b. COUNTY <i>Baltimore</i> | |
| c. LENGTH OF STAY IN 1b <i>Rural</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>409 E. Penna. Ave</i> | | d. STREET ADDRESS <i>409 E. Penna. Av</i> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <i>Addie</i> | | First <i>Alma</i> | Middle <i>Katherine</i> |
| 4. DATE OF DEATH Month <i>8</i> | | Month <i>17</i> | Day Year <i>1959</i> |
| 5. SEX <i>F</i> | | 6. COLOR OR RACE <i>C</i> | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <i>2-1-1892</i> | |
| 9. AGE (In years lost birthday) <i>67</i> yrs | | 10. IF UNDER 1 YEAR Months <i>0</i> | |
| 11. IF UNDER 24 HRS Days <i>0</i> | | 12. IF UNDER 24 HRS Hours <i>0</i> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Domestic</i> | |
| 11. BIRTHPLACE (State or foreign country) <i>Towson Ind</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>Towson Ind</i> | |
| 13. FATHER'S NAME <i>Joseph Johnson</i> | | 14. MOTHER'S MAIDEN NAME <i>Emma Myers</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no, or unknown) <i>No</i> | | 16. SOCIAL SECURITY NO. (If yes, give war or date of service) <i>Queen E. Taylor-4650, Railroad Av</i> | |
| 17. INFORMANT <i>Queen E. Taylor-4650, Railroad Av</i> | | 18. CAUSE OF DEATH [Enter only one cause, per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cancerous, Bronch</i> | |
| DUE TO <i>Lung</i> | | INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i> | |
| Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>Cerebral Thrombosis & heart enlargement</i> | | DUE TO <i>2 days</i> | |
| (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i> | | 20d. INJURY OCCURRED While or work <input type="checkbox"/> Not while or work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>8-17-59</i> to <i>8-17-59</i> , that I last saw the deceased alive on <i>8-17-59</i> , and that death occurred at <i>3:30 PM</i> , from the causes and on the date stated above ACTUAL SIGNATURE <i>Bennett A. Stoen</i> ADDRESS (Street, city, town, state) <i>19 W. Seminary Ave., Lutherville, Md.</i> DATE SIGNED <i>8/17/59</i> | | | |
| PHYSICIAN'S NAME (Type) <i>Bennett A. Stoen, M. D.</i> | | 19. W. Seminary Ave., Lutherville, Md. <i>8/17/59</i> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 22b. DATE THEREOF <i>8-20-59</i> | |
| 22c. NAME OF CEMETERY OR CREMATORIAL <i>Pleasant Rest Cem</i> | | 22d. LOCATION (City, town, or county) (State) <i>Towson Ind</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Samuel W. Sullivan Jr.</i> | | ADDRESS <i>Baltimore</i> | |
| 24a. REC'D BY REGISTRAR DATE <i>AUG 18 '59</i> | | 24b. REGISTRAR'S SIGNATURE <i>Archie S. Tamm</i> | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

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VS A15 (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

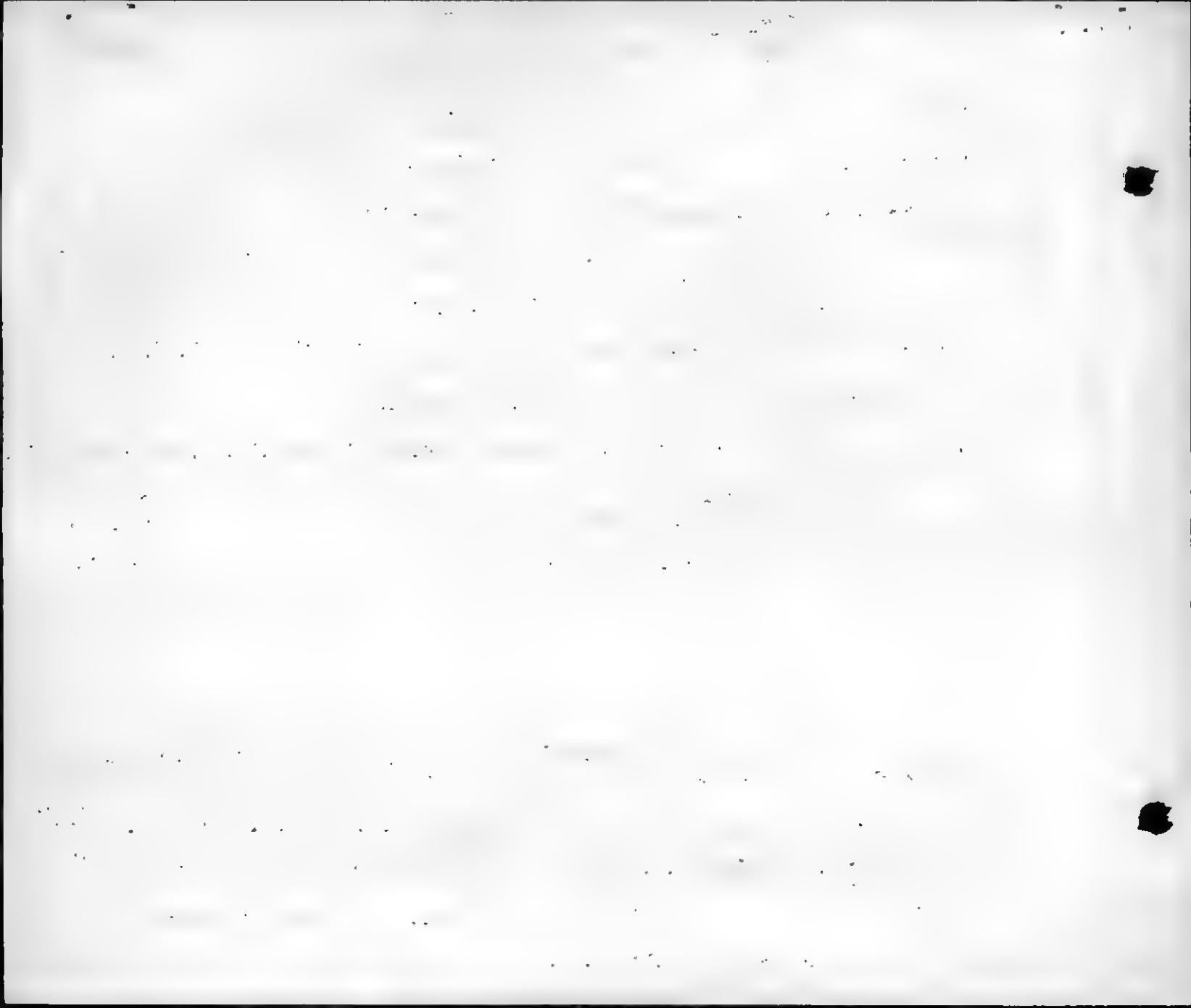
8847

CERTIFICATE OF DEATH

08812

Reg. Dist. No

| | | | | | | | | |
|---|-----------------------------|---|---------------------------------|---|--|---|-----------|--------------|
| 1. PLACE OF DEATH a. COUNTY Baltimore | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland | | b. COUNTY | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard | | c. LENGTH OF STAY IN lb 12 Days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (16) | | d. STREET ADDRESS 2914 Poplar Terrace | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL | | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) | | First JOHN | Middle H. | Lost KIMBROUGH | 4. DATE OF DEATH August 25 1959 | Month August | Day 25 | Year 1959 |
| 5. SEX Male | 6. COLOR OR RACE Colored | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 2, 1908 | | 9. AGE (In years last birthday) 51 | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | | |
| 10a. US/JAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY Construction | | 11. BIRTHPLACE (State or foreign country) Darby, Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | |
| 13. FATHER'S NAME Henry Kimbrough | | | | 14. MOTHER'S MAIDEN NAME Addie Collins | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO. WW II 225-18-2041 | | INFORMANT Clinical Records, VAH, Balto 18, Md. Fort Howard Div. | | Address | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) URENTA | | | | | | | | |
| 4415X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO NEPHROSCLEROSIS | | | | | | | | |
| (c) DUE TO MALIGNANT HYPERTENSION | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | | | | |
| 20c. TIME OF INJURY Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that I attended the deceased from August 13, 1959, to August 25, 1959, had charge of the deceased and that death occurred at 10:15 PM and that death occurred at 10:15 PM, from the causes and on the date stated above. | | | | | | | | |
| ADDRESS (Street, city or town, state) | | | | | | | | |
| DATE SIGNED 8/26/59 | | | | | | | | |
| ACTUAL SIGNATURE <i>John W. Crawford</i> | | | | | | | | |
| PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, M.D. | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF ✓ | | 22c. NAME OF CEMETERY OR CREMATORIAL Baltimore National Cem. | | 22d. LOCATION (City, town, or county) Baltimore Maryland (State) | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Elroy Wilson, 1000 Brantley St. Balto. Md. | | | | | | | | |
| ADDRESS | | | | 24a. REC'D BY REGISTRAR DATE SEP 8 '59 | | 24b. REGISTRAR'S SIGNATURE C. Irving & Trahan | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8848

CERTIFICATE OF DEATH

08813

Reg. Dist. No.

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE | |
| Baltimore | | Md. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Maryland Line | | b. COUNTY | |
| c. LENGTH OF STAY IN 1b 25 yrs. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Maryland Line | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS | |
| | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | | 4. DATE OF DEATH August 5, 1959 | |
| First Effie | | Middle L. Kinard. | |
| 5. SEX F | | 6. COLOR OR RACE W | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH March 7, 1884 | |
| 9. AGE (In years at death) 75 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operator | | 10b. KIND OF BUSINESS OR INDUSTRY Sewing Factory | |
| 11. BIRTHPLACE (State or foreign country) Parkton, Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Oliver F. Lowe | | 14. MOTHER'S MAIDEN NAME Rosa Grover | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO 180-03-8202 | |
| 17. INFORMANT Mrs. Paul Hoffacker, Md. Line, Md. | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Cerebral Vascular Hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Cerebral Vascular Hemorrhage (c) INTERVAL BETWEEN ONSET AND DEATH | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER) | |
| 20a. TIME OF INJURY Hour o. m. p. m. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. INJURY OCCURRED While Not while of work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>1 July</u> , 1959, to <u>4 August</u> , 1959, that I last saw the deceased alive on <u>4 August</u> , 1959, and that death occurred at <u>3:45 P.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>Reginald B. Geamill</u> M.D. ADDRESS <u>Stewartstown, Pa.</u> DATE SIGNED <u>August 1959</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Aug. 8, 1959 | |
| 22c. NAME OF CEMETERY OR CREMATORIUM New Freedom Cemetery | | 22d. LOCATION (City, town, or county) New Freedom, Pa. (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Jacob Kortensten, New Freedom, Pa. | | 24a. REC'D BY REGISTRAR DATE AUG 10 '59 | |
| 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8849

CERTIFICATE OF DEATH

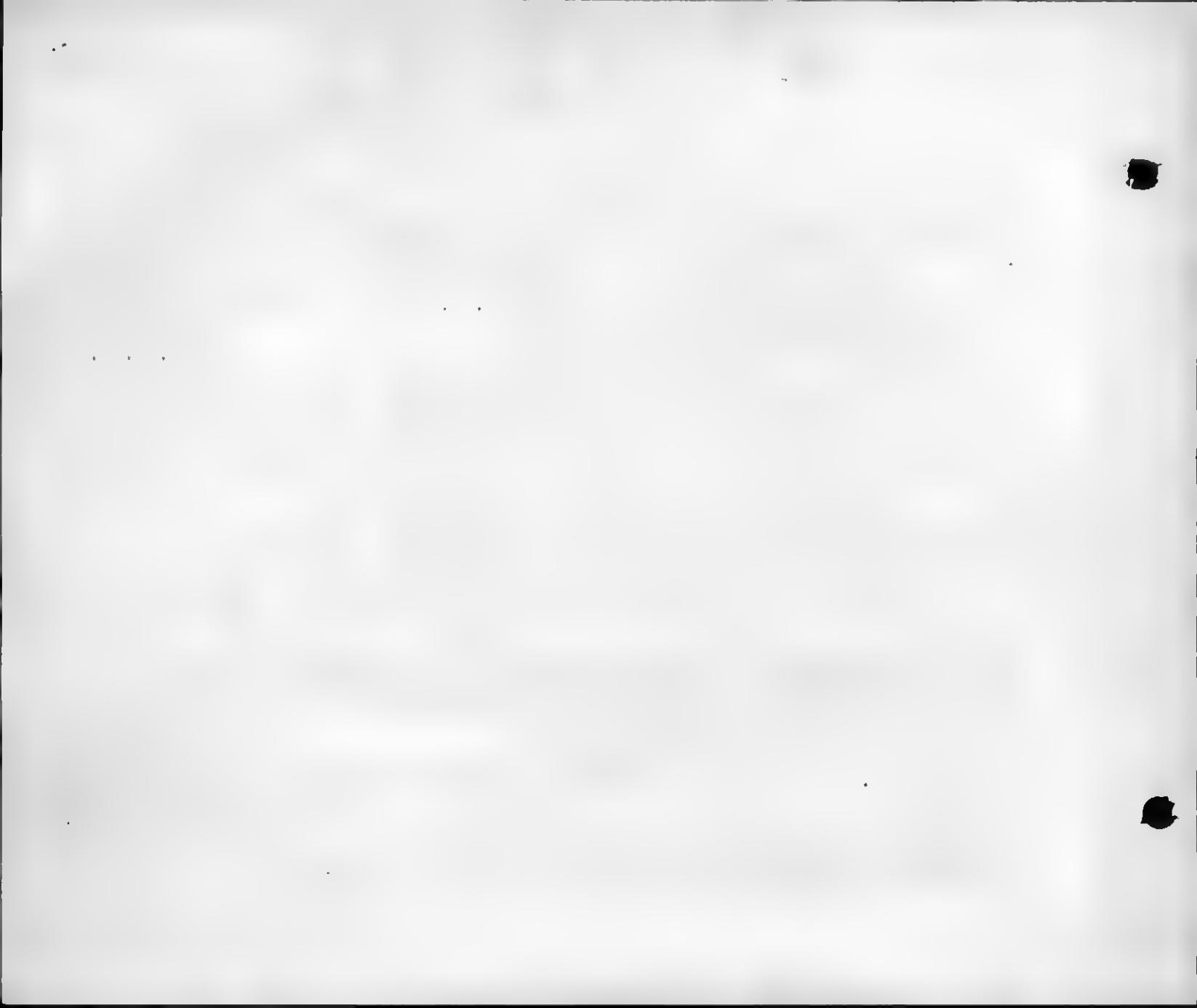
Reg. Dist. No.

08814

TO HOSPITAL OR HOSPITAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | | | |
|--|--|---|---|---|--|--|-----------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived) | | If institution | | Residence before admission | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catoonsville | | c. LENGTH OF STAY IN 1b 11yr2mth11dys | | a. STATE Maryland | | b. COUNTY | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | | d. STREET ADDRESS 3109 Gibbons Avenue | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Margaret | | First | Middle | Losl | 4. DATE OF DEATH August | Month | Day | Year | |
| 5. SEX female | | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH Nov. 1, 1892 | 9. AGE (In years last birthday) 66 | 10. IF UNDER 1 YEAR Months | 11. IF UNDER 24 HRS Days | 12. IF UNDER 24 HRS Hours | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY U. S. A. | | | |
| 13. FATHER'S NAME Henry Kinlein | | | | 14. MOTHER'S MAIDEN NAME Dorothea Stengel | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. Unknown | | 17. INFORMANT Records: SPRING GROVE STATE HOSPITAL | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> | | | | | | | | | |
| DUE TO | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) <u>Arteriosclerotic cardiovascular disease</u> | | | | | | | | | |
| DUE TO | | | | | | | | | |
| (c) <u>Generalized arteriosclerosis</u> | | | | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from <u>July 1, 1955</u> to <u>Aug. 19, 1959</u> that I last saw the deceased alive on <u>Aug. 19, 1959</u> , and that death occurred at <u>4:45 P.M.</u> from the causes and on the date stated above | | ADDRESS (Street, city or town, state) | | | | | | | |
| ACTUAL SIGNATURE <i>Stella Wachsler</i> | | M.D. SPRING GROVE STATE HOSPITAL 8-20-59 | | | | | | | |
| PHYSICIAN'S NAME (Type) Stella Wachsler, M. D. | | Catonsville 28, Lary and | | | | | | | |
| 22a. BURIAL CREMATION, REMOVAL (Specify) 8/20/59 | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORIAL Holy Redeemer | | 22d. LOCATION (City, town, or county) Baltimore | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Zinaida Hock 5305 Haiford</i> | | ADDRESS | | 24a. REC'D BY REGISTRAR DATE AUG 21 '59 | | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Evans</i> | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

X1

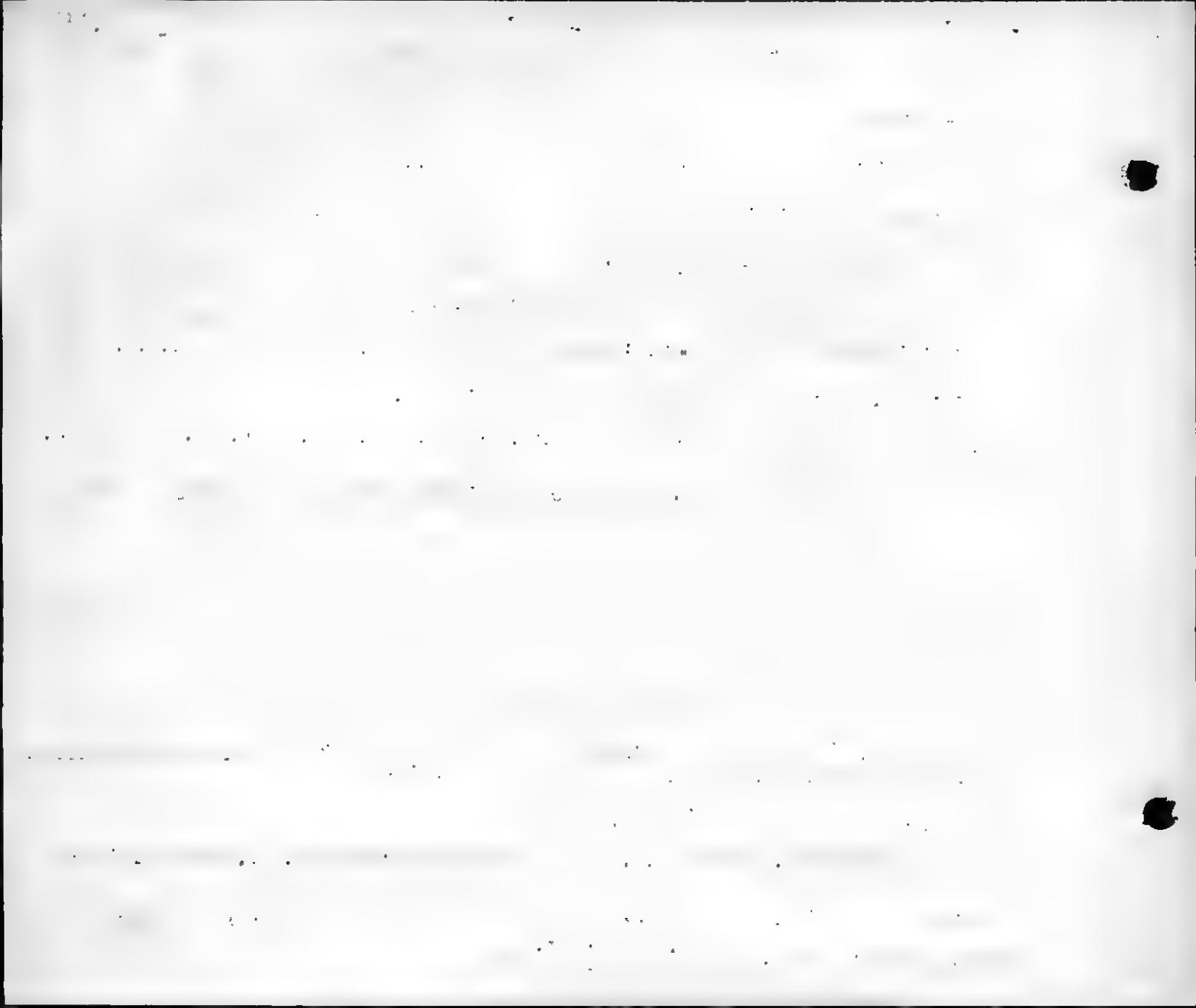
8850

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 08815

| | | | | | | | |
|---|------------------------------------|---|---|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland | | b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard | | c LENGTH OF STAY IN lb 21 days | | c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital | | d. STREET ADDRESS 1924 Light Street | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) GEORGE | First | Middle | Last | 4. DATE OF DEATH KIRBY | Month August | Day 29 | Year 19 59 |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH December 24, 1893 | 9. AGE (In years last birthday) 65 yr | 10. IF UNDER 1 YEAR Months 0 | 11. IF UNDER 24 HRS Hours 0 |
| 10a. US/JAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver | | 10b. KIND OF BUSINESS OR INDUSTRY Meat Company | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME George B. Kirby | | | | 14. MOTHER'S MAIDEN NAME Mary E. Fredericks | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO 215-09-4354 | | INFORMANT Clin. Records, Vet. Adm. Hosp. Ft. Howard, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) ADENOCARCINOMA OF THE STOMACH WITH CARCINOMATOSIS UNKNOWN DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDIT ON GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Hour o. m. p. m. | Month 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) | |
| 21. I certify that / attended the deceased from August 8, 1959 , to August 29, 1959 , and that death occurred at 9:55AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, Baltimore, Md.-Ft. Howard Division DATE SIGNED Lawrence D. Marcus | | | | | | | |
| ACTUAL SIGNATURE <i>Lawrence D. Marcus</i> | | M.D. | | | | | |
| PHYSICIAN'S NAME (Type) LAWRENCE D. MARCUS, M.D. | | VAH, Baltimore, Md.-Ft. Howard Division | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 9/1/59 | 22c. NAME OF CEMETERY OR CREMATORIUM Glen Haven Memorial Gardens | 22d. LOCATION (City, town, or county) (State) Baltimore, Maryland | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE McCully Funeral Home, Baltimore 30, Maryland | | ADDRESS 130 E. Fort Avenue | 24a. REC'D BY REGISTRAR Aug 31 '59 | 24b. REGISTRAR'S SIGNATURE Arthur G. Kline | | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8851

CERTIFICATE OF DEATH

Reg. Dist. No.

119956

TO HOSPITAL OR CLINIC: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|--|---------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | c. LENGTH OF STAY IN 1b 23 yr 9 mth 11 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Charles Middle Edward Last Klein | | 4. DATE OF DEATH August 23 | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH Sept. 16, 1898 |
| 9. AGE (In years last birthday) 60 yrs | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) painter | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Fred W. Klein | | 14. MOTHER'S MAIDEN NAME Ida Mariner | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown | | 16. SOCIAL SECURITY NO Unknown | |
| 17. INFORMANT Records; SPRING GROVE STATE HOSPITAL | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 428.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Generalized arteriosclerosis DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Doy, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |
| 20f. (City or town) | | (County) (State) | |
| 21. I certify that I attended the deceased from Aug. 14, 1959, to Aug. 23, 1959, that I last saw the deceased alive on Aug. 23, 1959, and that death occurred at 8:45 a.m. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Stella Wachsler | | ADDRESS (Street, city or town, state) M.D. SPRING GROVE STATE HOSPITAL DATE SIGNED 9-1-59 | |
| PHYSICIAN'S NAME (Type) Stella Wachsler, M. D. | | Catonsville 28, Maryland | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) ✓ | | 22b. DATE THEREOF 9/10/59 | 22c. NAME OF CEMETERY OR CREMATORIUM U. of Md. Med. School |
| 23. FUNERAL DIRECTOR'S SIGNATURE VS A15 (4) 1SM 10/57 | | 22d. LOCATION (City, town or county) Baltimore, Md. | (State) |
| ADDRESS | | 24a. REC'D BY REGISTRAR DATE SEP 11 '59 | 24b. REGISTRAR'S SIGNATURE Chas. & Evans |



TO HOSPITAL OR ENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death).

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

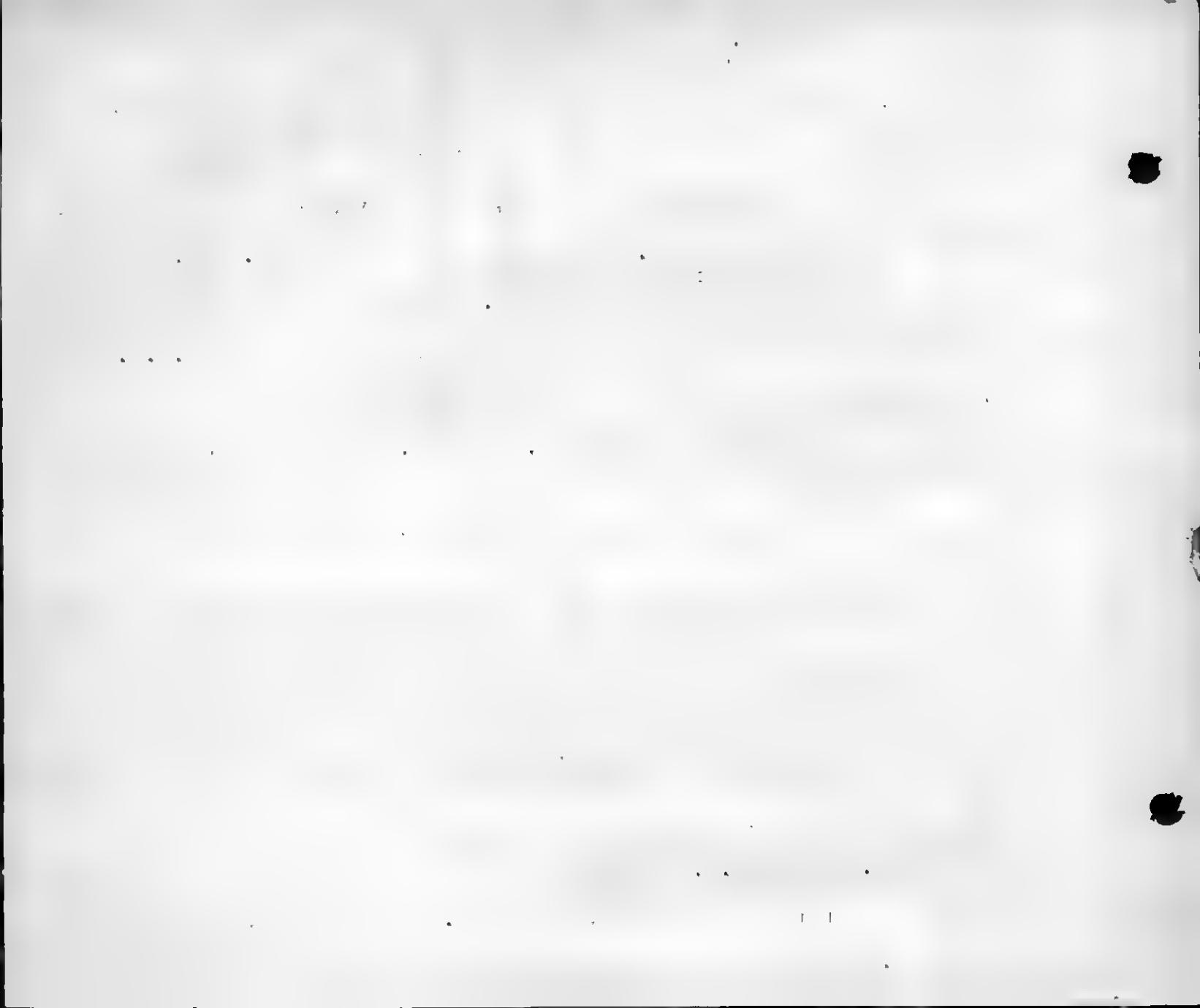
8763

CERTIFICATE OF DEATH

08816

Reg. Dist. No.

| | | | |
|--|---|--|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write BURG and give nearest town) Baltimore Arthur Life | | c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore Arthur Life | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4401 John Avenue | | d. STREET ADDRESS 4401 John Avenue | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) George S. Knecht | First | Middle | Last |
| 4. DATE OF DEATH Aug. 29, 1959 | Month | Day | Year |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Nov. 27, 1884 |
| 9. AGE (In years lost birthday) 74 yrs. | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired | 11. BIRTHPLACE (State or foreign country) Maryland | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME John Knecht | 14. MOTHER'S MAIDEN NAME Mary Kaiser | 15. SOCIAL SECURITY NO 215 07 7681 | |
| 16. INFORMANT Mrs. Helen B. Knecht 4401 John Avenue | Address | | |
| 17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary Thrombosis INTERVAL BETWEEN ONSET AND DEATH | | | |
| 18. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 19. MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>Aug 20</u> , 1959, to <u>Aug 29</u> , 1959, that I last saw the deceased alive on <u>Aug 29</u> , 1959, and that death occurred at <u>88</u> M, from the causes and on the date stated above. ACTUAL SIGNATURE <u>Dr. George S.M. Kieffer</u> M.D. ADDRESS (Street, city or town, state) <u>1010 Reeds Ave</u> DATE SIGNED <u>Aug 31, 1959</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 9/2/59 | 22c. NAME OF CEMETERY OR CREMATORIALorraine Park Cem. |
| 22d. LOCATION (City, town, or county) Baltimore, Maryland | | 24a. REC'D BY REGISTRAR DATE <u>SEP 1 '59</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard 4107 Wilkens Avenue | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8852 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08817

Reg. Dist. No.

| | | | | | | | | | | | |
|---|--|-------------------------|--|---|--------|------------------|------------------|--|-----|------------------------|--|
| 1. PLACE OF DEATH a. COUNTY | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) | | | | | | | |
| Baltimore MARYLAND | | | | a. STATE Md. b. COUNTY Baltimore | | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. LENGTH OF STAY IN lb | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | | | | | | |
| Balto. 7 | | 4 yrs. | | Baltimore 7 | | | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | | | d. STREET ADDRESS | | | | | | | |
| 6719 Campfield Rd. | | | | 6719 Campfield Road | | | | | | | |
| e. IS RESIDENCE ON A FARM? | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) | | | | First | Middle | Last | 4. DATE OF DEATH | Month | Day | Year | |
| Jennie C. Kohlbauer | | | | August | 31, | 19 | 59 | | | | |
| 5. SEX | | 6. COLOR OR RACE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH | | 9. AGE (in years last b. day) | | 10. IF UNDER 1YEAR | |
| Female | | White | | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | Decemb 31, 1874 | | 84 yrs. | | Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (State or foreign country) | | | |
| Housewife | | | | On home | | | | Maryland | | | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | | 12. CITIZEN OF WHAT COUNTRY? | | | |
| John Parrish | | | | Mary C. Weir | | | | U.S.A. | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | | | 16. SOCIAL SECURITY NO. | | | | 17. INFORMANT | | | |
| No | | | | 217-32-9167 | | | | Address: Baltimore 7, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | 19. WAS AUTOPSY PERFORMED? | | | | | | | |
| PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| Epilepsy | | | | 23 yrs. | | | | | | | |
| 3532 | | | | DUE TO | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | (b) | | | | 23 yrs. | | | |
| DUE TO | | | | (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) | | | | 19. WAS AUTOPSY PERFORMED? | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. none | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20c. TIME OF INJURY Month, Day, Year | | | | 20d. INJURY OCCURRED | | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | |
| Hour a. m. none | | | | While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> none | | | | 20f. (City or town) (County) (State) | | | |
| p. m. 19 | | | | | | | | none | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | DATE SIGNED | | | |
| D. D. Caples, M. D. | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | 9-2-59 | | | |
| EXAMINER'S NAME (Type) | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | | | 22b. DATE THEREOF | | | | 22c. NAME OF CEMETERY OR CREMATORIAL | | | |
| Burial | | | | Sept. 3, 1959 | | | | 22d. LOCATION (City, town, or county) (State) | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE | | | | ADDRESS | | | | Parkville Md. | | | |
| Frank H. Newell, Pikesville | | | | 8719 Campfield Rd. | | | | REC'D BY REGISTRAR | | | |
| | | | | DATE SEP 8 '59 | | | | 24b. REGISTRAR'S SIGNATURE | | | |
| | | | | | | | | Arthur & Thorne | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate in a padded envelope and mail to the Chief Medical Examiner's Office along with Farm PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death
 may be retained by the hospital or attending physician.

2 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
 ISM 9/58

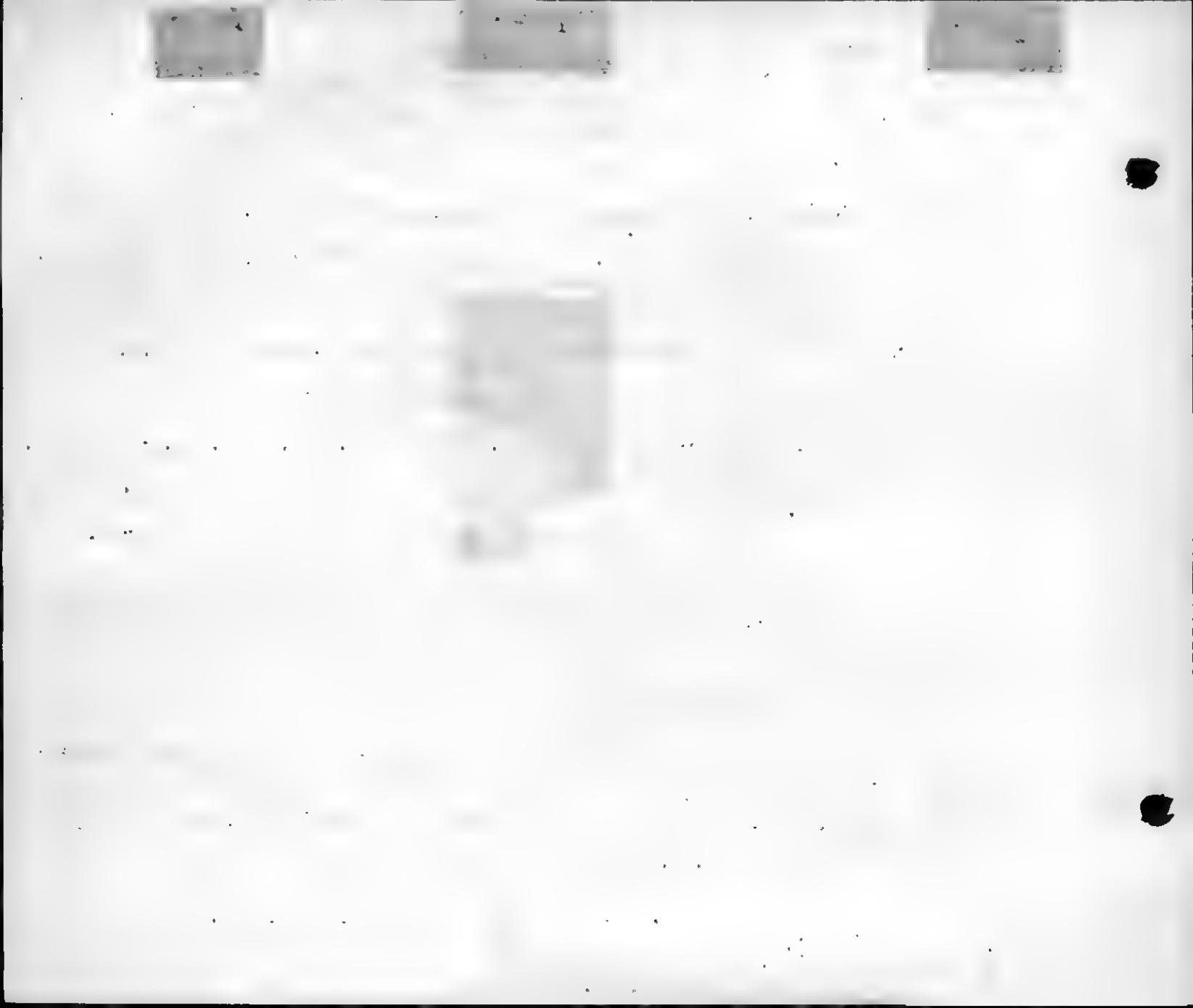
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8853 Item 9 Film G240 CERTIFICATE OF DEATH

Reg. Dist. No.

08818

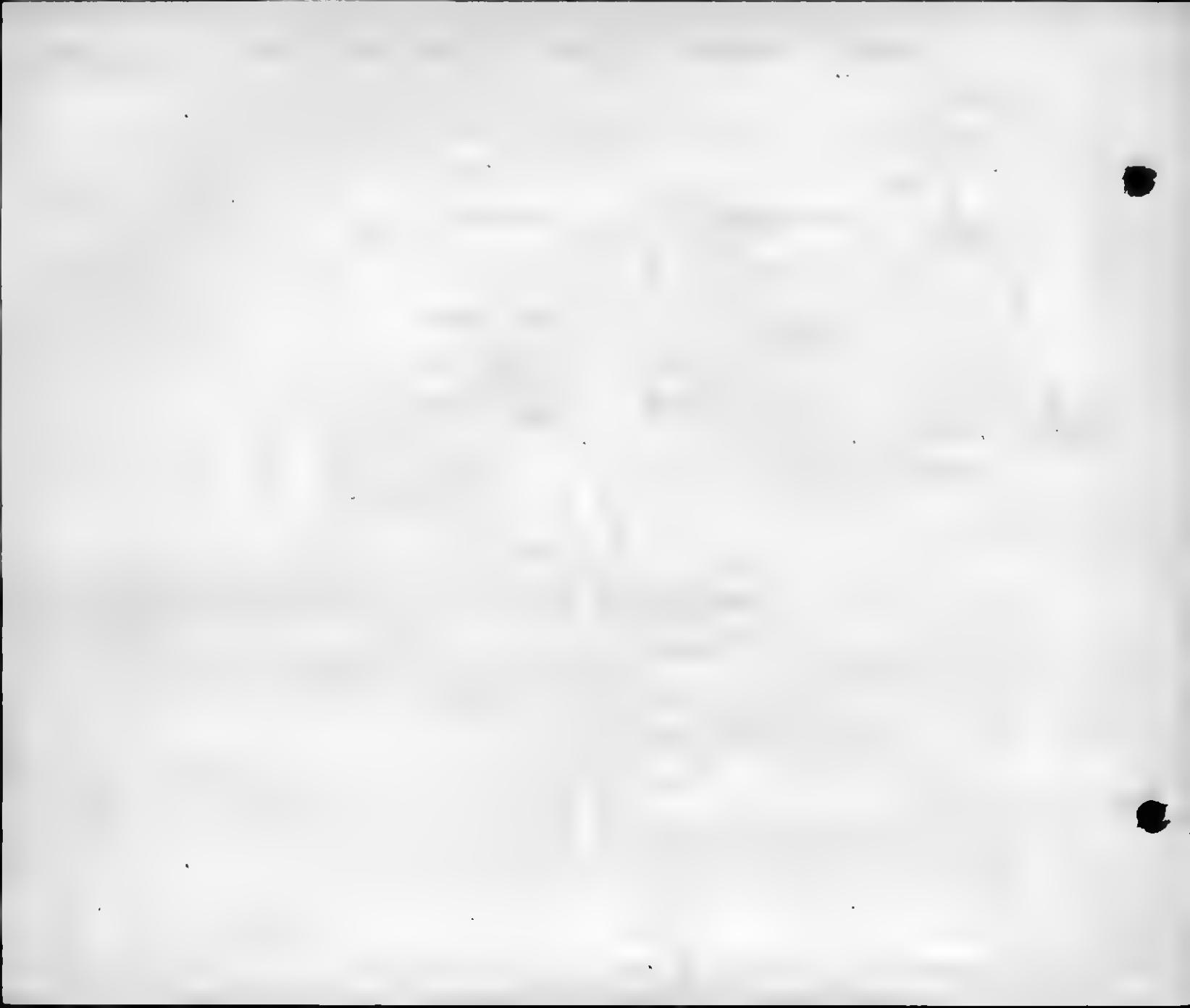
| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | |
| d. LENGTH OF STAY IN TB 8 Days | | e. STREET ADDRESS 833 Back River Neck Road | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | First BERNARD | Middle L. | Last KROL |
| 4. DATE OF DEATH | Month August | Day 30 | Year 19 59 |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH December 19, 1927 |
| 9. AGE (In years last birthday) 31 02 yrs. | 10. IF UNDER 1 YEAR Months 3 | 11. IF UNDER 24 HRS Days 18 | 12. Hours 00 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter | 10b. KIND OF BUSINESS OR INDUSTRY Construction(Houses) | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | 12. CITIZEN OF WHAT COUNTRY? U.S.A |
| 13. FATHER'S NAME Peter Krol | | 14. MOTHER'S MAIDEN NAME Catherine Ziembra | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO. 215-24-6915 | |
| 17. INFORMANT Clin. Records, Vet. Adm. Hosp. Ft. Howard, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LYMPHOSARCOMA | | | |
| INTERVAL BETWEEN ONSET AND DEATH UNKNOWN | | | |
| 200.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) | | ACUTE LYMPHATIC LEUKEMIA UNKNOWN | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| CHRONIC PYELONEPHRITIS | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from August 22, 1959 to August 30, 1959 and that death occurred at 3:25 AM , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>Charles Allen</i> | | ADDRESS (Street, city or town, state) M.D. VAH, Fort Howard, Maryland DATE SIGNED 8/30/59 | |
| PHYSICIAN'S NAME (Type) CHARLES ALLEN, M. D. | | VAH, Fort Howard, Maryland 8/30/59 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 9-2-59 | |
| 22c. NAME OF CEMETERY OR CREMATORIAL St. Stanislaus Cemetery | | 22d. LOCATION (City, town, or county) Baltimore, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>James J. Bruzdzienski</i> | | ADDRESS 1107 Eastern Ave. | |
| 24a. REC'D BY REGISTRAR SEP 2 '59 | | 24b. REGISTRAR'S SIGNATURE Orton & Kress | |
| VS A15 (4) ISM 9/58 | | | |



TO DEPUTY ATTORNEY: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Logs 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

| MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 | | | | | | | | | |
|---|--|--|---|---|---|---------------------------------------|--|---------|------------------|
| 8758 MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | |
| Reg. Dist. No. 08819 | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY | | BALTO. MARYLAND | | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | DUNDALK | | | | | | | |
| c. LENGTH OF STAY IN 1b | | 3 MONTHS | | | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | 1737 STOKESLEY RD. | | | | | | | |
| 3. NAME OF DECEASED (Type or print) | | First | Middle | Last | 4. DATE OF DEATH | Month | Day | Year | |
| S. SEX | | 6. COLOR OR RACE | 7. MARRIED | NEVER MARRIED | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| MALE | | WHITE | WIDOWED | DIVORCED | DEC. 23, 1918 | 40 yrs. | Months | Days | Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | | | |
| SHIP YARD WORKER, SPARROWS PT. | | | | MD. | | USA | | | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | | | | | | |
| HENRY LAMBDIN | | BARBARA FROHN | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address 1737 STOKESLEY RD (22) MD. | | | |
| YES | | WVII 813-05-5567 | | MRS. DOLORES LAMBDIN | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) | | Coronary Occlusion | | | | | | | |
| 420.1 DUE TO | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) | | | | | | | | | |
| DUE TO | | | | | | | | | |
| (c) | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Hour a. m. p. m. | | Month, Day, Year 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE | | M. B. Davis | | | | | | | |
| EXAMINER'S NAME (Type) | | M. B. DAVIS MD | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORIAL | | 22d. LOCATION (City, town, or county) | | (State) | |
| BURIAL | | 8/19/59 | | BALTO. NATIONAL | | BALTO. | | MD. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | | 24a. REC'D BY REGISTRAR | | 24b. REGISTRAR'S SIGNATURE | | | |
| George W. Hoffmann 3218 HUDSON ST. | | | | DATE 19 '59 | | G. W. Hoffmann | | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08820

8759

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk | | c. LENGTH OF STAY IN 1b c. LENGTH OF STAY IN 1b | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7524 Rabon Avenue | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) BONITA | | First LOUISE | Middle LARRIMORE |
| 4. COLOR OR RACE Female | | 5. SEX White | 6. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 7. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 8. DATE OF BIRTH May 31, 1958 | | 9. AGE (In years from birthday) 35 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY Maryland | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME Daniel Larrimore | | 14. MOTHER'S MAIDEN NAME Yvonne Fetterhoff | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 7514.5 | | 16. SOCIAL SECURITY NO. 17. INFORMANT Daniel Larrimore, 7524 Rabon Avenue | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congenital heart disease | | Address INTERVAL BETWEEN ONSET AND DEATH | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. DUE TO (b) (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Naturol causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <i>William V. Lovitt</i> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D. | | DATE SIGNED 8/25/59 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 8-27-59 | |
| 22c. NAME OF CEMETERY OR CREMATORIAL Baltimore National | | 22d. LOCATION (City, town, or county) Baltimore | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight, Inc., 6009 Harford Road | | 24a. REC'D BY REGISTRAR DATE AUG 26 '59 | |
| | | 24b. REGISTRAR'S SIGNATURE Arthur L. Kline | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

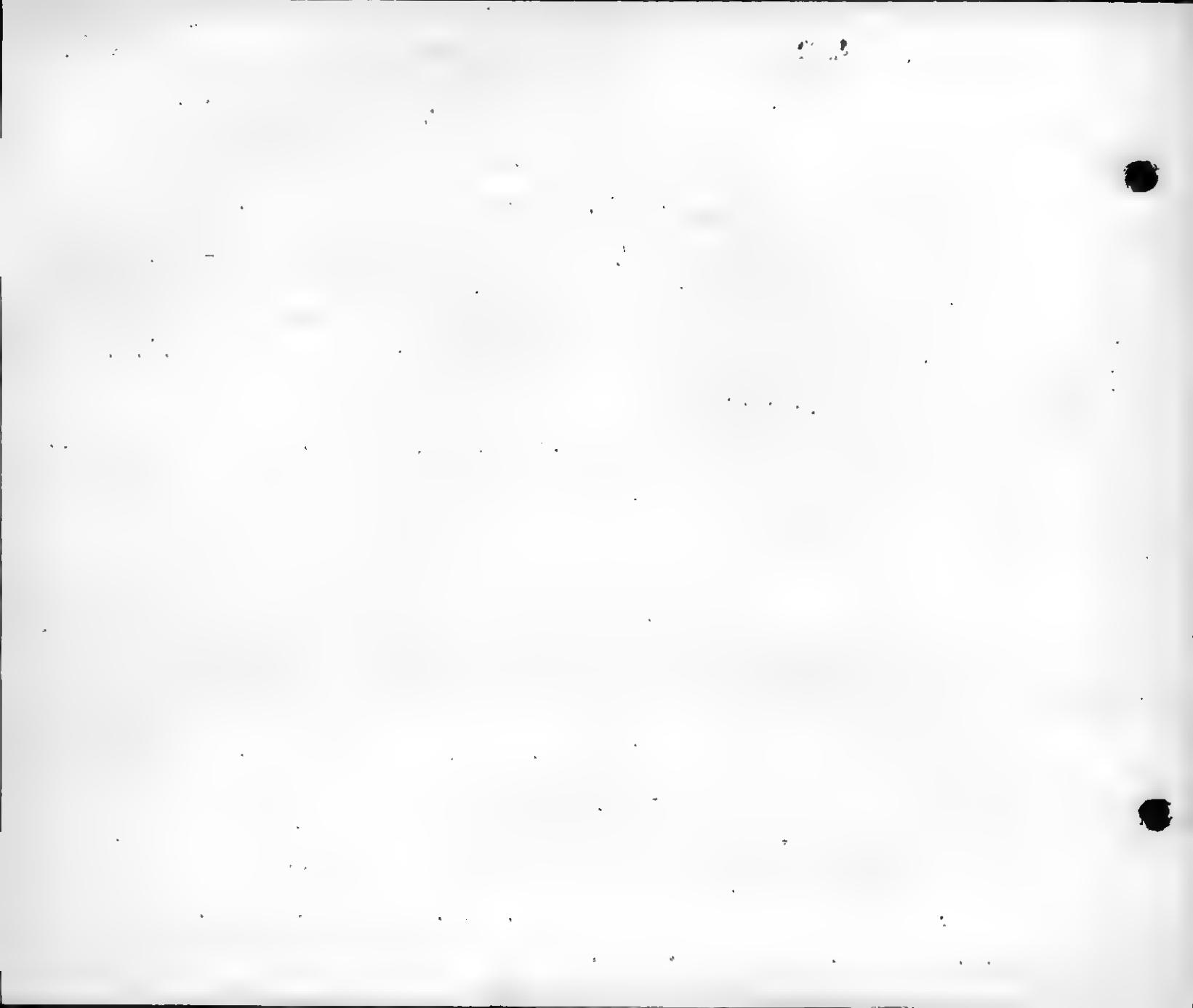
08822

8854

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

| | | | |
|--|---------------------------|--|-----------------------------------|
| 1. PLACE OF DEATH a. COUNTY Baltimore | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. LENGTH OF STAY IN 1b MARYLAND | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8510 Chestnut Oak Rd. | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | |
| 3. NAME OF DECEASED (Type or print) Anita | | First J. | Middle Linder |
| 4. DATE OF DEATH 8 | Month - 24 | Day - 19 | Year 59 |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH March 2, 1884 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Germany | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Paul C. Gonnen | | 14. MOTHER'S MAIDEN NAME Marie Pruss | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. INFORMANT Marie Merryman 8510 Chestnut Oak Rd. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH Cerebral vascular accident Year: 1951 and date: Mar 24, 1951 | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Salaried insurance | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Aug. 11, 1951</u> to <u>Aug. 14, 1951</u> that I last saw the deceased alive on <u>Aug. 24, 1951</u> , and that death occurred at <u>5:45 P.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE Dr. Albert L. M.D. | | ADDRESS (Street, city or town, state) DATE SIGNED 1951 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 8/28/59 | |
| 22c. NAME OF CEMETERY OR CREMATORIAL Monkton Meth. Cem. | | 22d. LOCATION (City, town, or county) (State) Monkton, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE L.J. Ruck, Inc. 5305 Harford Rd. # 14 | | 24a. REC'D BY REGISTRAR DATE AUG 27 '59 | |
| | | 24b. REGISTRAR'S SIGNATURE Arthur S. Krause | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8855 Item 7 File 6245 8-13-59 et
CERTIFICATE OF DEATH

Reg. Dist. No. 32

| | | | | | | | | |
|--|----------------------------------|---|------------------------------------|---|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE MARYLAND | | b. COUNTY | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson | | c. LENGTH OF STAY IN 1b 6 MONTHS | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital | | | | d. STREET ADDRESS 14 PRESTON STREET | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) S PAULDING EDWARD LOCKARD | | First | Middle | Last | 4. DATE OF DEATH 8-5 | Month | Day | Year 1959 |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH 6.11.97 | 9. AGE (In years last birthday) 62 | 10. IF UNDER 1 YEAR Months 6 | 11. IF UNDER 24 HRS Days 2 | 12. IF UNDER 24 HRS Hours 0 | 13. IF UNDER 24 HRS Min. 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A | | |
| 13. FATHER'S NAME PHILLIP LOCKARD | | 14. MOTHER'S MAIDEN NAME MARY HOGARTY | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO. | | 16. SOCIAL SECURITY NO. 215-05-8698 | | 17. INFORMANT Hospital Records, Mt. Wilson State Hospital | | Address | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cervical carcinoma of lung n.s. | | DUE TO | | INTERVAL BETWEEN ONSET AND DEATH | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. | | (b) DUE TO | | (c) | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | | | | |
| 21. I certify that I attended the deceased from 2-18-1959 to 8-5-1959 , that I last saw the deceased alive on 8-4-1959 , and that death occurred at 40 AM , from the causes and on the date stated above. | | | | ADDRESS (Street, city or town, state) Mt. Wilson, Maryland | | DATE SIGNED 8-5-59 | | |
| ACTUAL SIGNATURE William Newcomer | | M.D. | | | | | | |
| PHYSICIAN'S NAME (Type) William Newcomer, M.D. | | | | Superintendent | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 8-10-59 | | 22c. NAME OF CEMETERY OR CREMATORIAL St. Charles Cemetery | | 22d. LOCATION (City, town, or county) Oliverelle | | (State) |
| 23. FUNERAL DIRECTOR'S SIGNATURE Frank H. Newell | | ADDRESS Pikesville | | 24. REC'D BY REGISTRAR DATE AUG 10 '59 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kline | | |



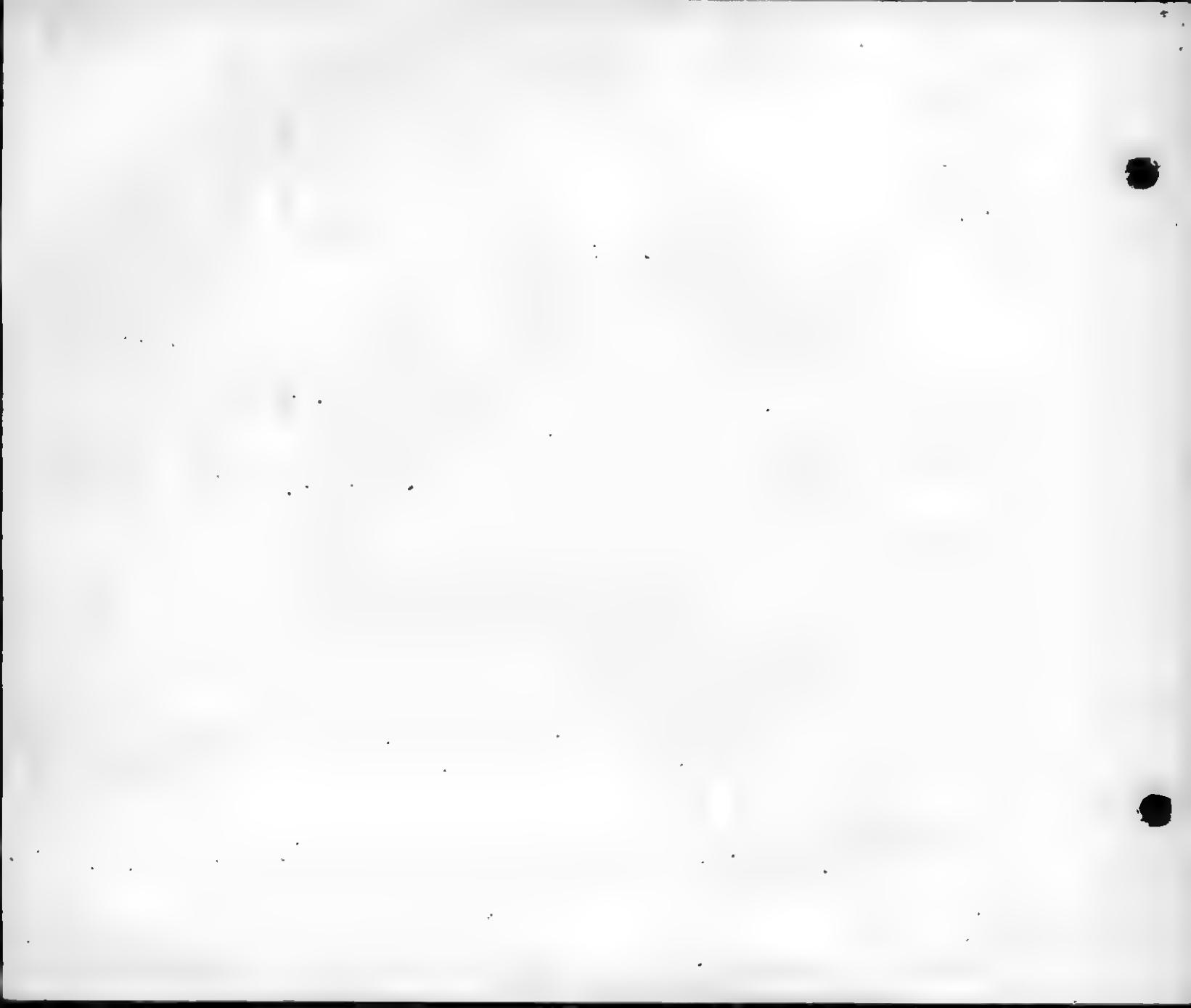
TO HOSPITAL OR ENDING PHYSICIAN: This low requires that the death certificate be executed within 24 hours of death. Page 4
 may be retained by the hospital or attending physician
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8856 CERTIFICATE OF DEATH

05824
Reg. Dist. No.

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY BALTIMORE | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE | | c. LENGTH OF STAY IN 1b 4 yrs. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1004 KENT AVE | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE | |
| 3. NAME OF DECEASED (Type or print) HELEN MILLER | | First HELEN Middle BLANCHE Last Longan | 4. DATE OF DEATH August 28, 1959 |
| 5. SEX FEmaLE | | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 8. DATE OF BIRTH FEB 16, 1886 | | 9. AGE (In years lost birthday) 73 yrs | 10. IF UNDER 1 YEAR <input type="checkbox"/> UNDER 24 HRS Months 0 Days 0 Hours 0 Min 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine Operator | | 10b. KIND OF BUSINESS OR INDUSTRY Clothing, Mfg. | 11. BIRTHPLACE (State or foreign country) Pennsylvania |
| 13. FATHER'S NAME Christian C MILLER | | 14. MOTHER'S MAIDEN NAME DORA MARTZ | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. 215-67-6940 | INFORMANT Evelyn Brady 1004 KENT AVE |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 4 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH Heart Disease Arteriosclerotic 4 yrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from 6/31/1959 to 8/28/1959 that I last saw the deceased alive on 8/28/1959 , and that death occurred at 9:30 AM , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE C. Mendelis | | ADDRESS (Street, city or town, state) 651 N Bentallow St Baltimore Md | |
| PHYSICIAN'S NAME (Type) C. Mendelis | | DATE SIGNED | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 8-31-59 | 22c. NAME OF CEMETERY OR CREMATORIAL Loudon Park |
| 23. FUNERAL DIRECTOR'S SIGNATURE Geo L. Schwab Funeral Home | | 23. ADDRESS Glennies St. Miller 2101 Frederick Ave | 24a. REC'D BY REGISTRAR DATE SEP 1 '59 |
| | | | 24b. REGISTRAR'S SIGNATURE Callie S. Thompson |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08825

8769

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | |
|--|------------------------------|---|--|---|--|---------------------|
| 1. PLACE OF DEATH a. COUNTY Balto | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto. | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1240 Circle Drive | | d. STREET ADDRESS 1240 Circle Drive | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) | First VELMA | Middle JACOBS | Last LYNCH | 4. DATE OF DEATH Aug. 27, 1959 | Month Year | |
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Nov. 2, 1906 | 9. AGE (In years last birthday) 52 yrs | 10. IF UNDER 1 YEAR Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY at home | 11. BIRTHPLACE (State or foreign country) Md. | 12. CITIZEN OF WHAT COUNTRY? | | |
| 13. FATHER'S NAME John George Jacobs | | 14. MOTHER'S MAIDEN NAME Sarah Catherine Miller | | Address | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes | | 16. SOCIAL SECURITY NO. World War II 213-28-8000 | 17. INFORMANT Mr. Edmond J. Lynch - 1240 Circle Drive | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Hour a. m. p. m. | Month 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) Baltimore | (County) Baltimore | (State) Maryland |
| 21. I certify that I attended the deceased from <u>August 21, 1959</u> to <u>August 27, 1959</u> that I last saw the deceased alive on <u>August 25, 1959</u> , and that death occurred at <u>6:00 P.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE C. ARTHUR ROSSBERG MD. PHYSICIAN'S NAME (Type) C. ARTHUR ROSSBERG MD. Baltimore 3, Maryland | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 8/31/59 | 22c. NAME OF CEMETERY OR CREMATORIUM Western Cemetery | 22d. LOCATION (City, town, or county) Baltimore, Maryland | (State) | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE H. J. Neff - Balt. 17 | ADDRESS | 24a. REC'D BY REGISTRAR DATE 8/31/59 | 24b. REGISTRAR'S SIGNATURE Arthur & H. J. Neff | | | |



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the funeral director. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AT 15 ME
SM 2/57

1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8857 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08826

Reg. Dist. No.

| | | | |
|---|--|---|------------------------|
| 1. PLACE OF DEATH a. COUNTY Baltimore, Maryland | | 2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE MD. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10-27 BALTIMORE 12 | | c. LENGTH OF STAY IN 1b 6 YRS | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 253 ADDRESSES FORGE RD | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X 10-27 BALTIMORE 12 | |
| 3. NAME OF DECEASED (Type or print) EMILY STEWART JACKLIN | | First | Middle |
| 4. DATE OF DEATH Month AUG Day 15 Year 1957 | | 5. SEX F | 6. COLOR OR RACE IV |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 10-26-72 | | 9. AGE (in years last birthday) 86 yrs | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HWF | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 10c. BIRTHPLACE (State or foreign country) MD. | | 11. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME WILLIAM A. STEWART | | 14. MOTHER'S MAIDEN NAME SLAUGHTER | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. — | |
| 17. INFORMANT EMILY S. STEWART CROSS 253 ADDRESSES FORGE RD. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIAL SCLEROTIC CARDIOPATHY DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 1 DAY | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour e. m. p. m. 19 | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | DATE SIGNED 8/15/57 | |
| ACTUAL SIGNATURE R. Edward T. Lee, M.D. | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) R. Edward T. Lee, M.D. | | 22. BURIAL, CREMATION OR REMOVAL (Specify) Burial Aug 19, 1959 GreenMount Cemetery | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Henry H. Jenkins & Sons Co. 4905 York Rd. | | 22d. LOCATION (City, town, or county) Baltimore, Md. (State) | |
| ADDRESS | | 24d. REC'D BY REGISTRAR AUG 17 '59 | |
| 24e. REGISTRAR'S SIGNATURE Arthur J. Keane | | | |



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

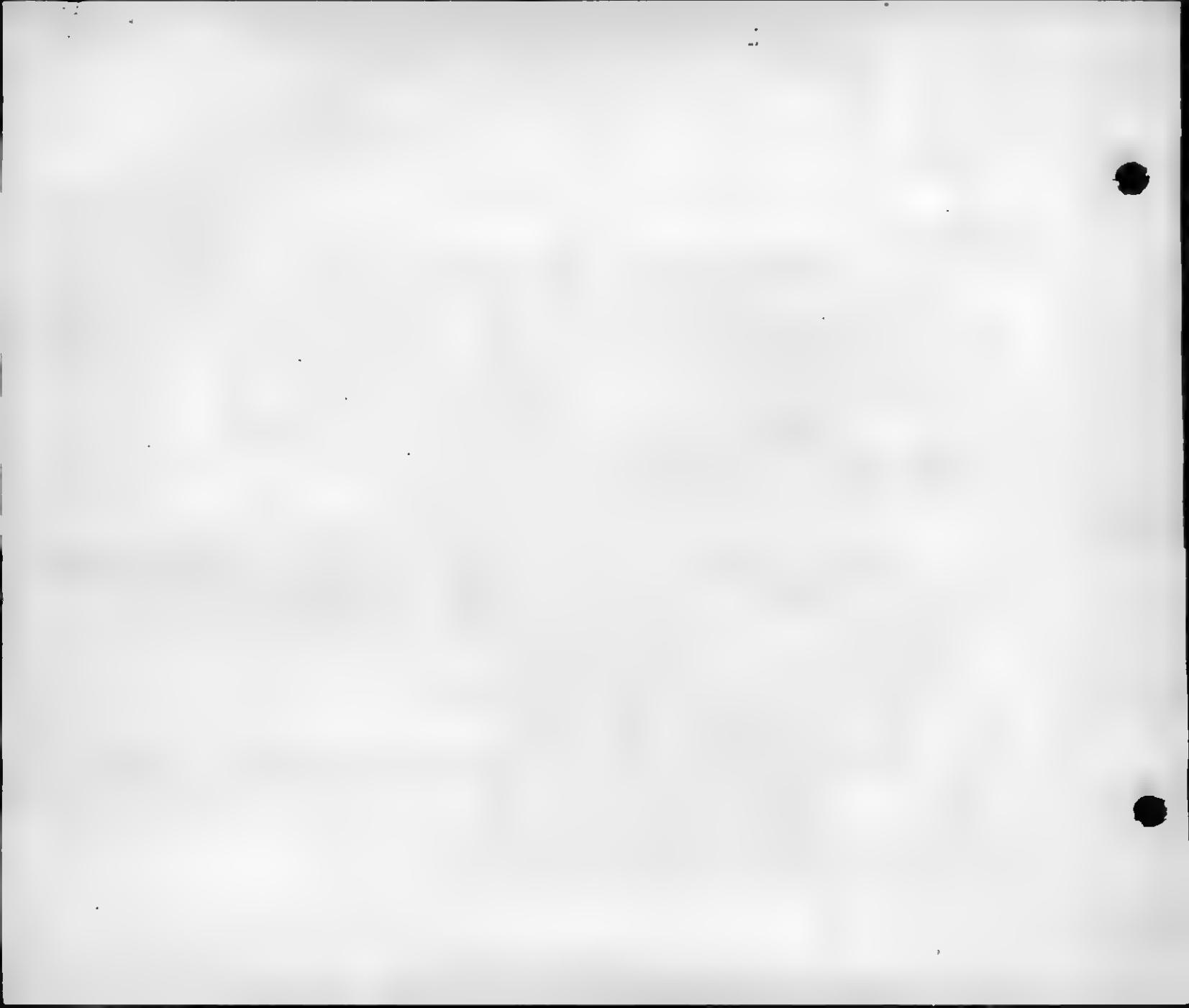
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8858 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10827

Reg. Dist. No.

| | | | | | |
|---|---|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY | 2646-Massachusetts Ave Edgewater, MARYLAND | 2. USUAL RESIDENCE (Where deceasedived. If institution, Residence before admission) a. STATE | Maryland | b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | Edgewater - Baltimore - 19 Summer Home | c. LENGTH OF STAY IN 1b | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | 2646 - Massachusetts Ave | d. STREET ADDRESS | BALTIMORE - 24 3916 - Foster Ave | | |
| 3. NAME OF DECEASED (Type or print) | William Evering Martell | 4. DATE OF DEATH | Month | Day | Year |
| 5. SEX | 6. COLOR OR RACE | 7. MARRIED WIDOWED | 8. DATE OF BIRTH | 9. AGE (In months, days, hours, minutes) | 10. IF UNDER 1 YEAR Months Days Hours Min. |
| Male | White | NEVER MARRIED | Sept. 28-1905 | 53 yrs | IF UNDER 24 HRS |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Electric Welder | | Bethlehem Steel | | BALTIMORE - Md. U.S.A. | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| William H. Martell | | Catherine Heidt | | Address | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO | | 17. INFORMANT | |
| No | | 213-09-0818 | | Sophia L. Martell, 3916-Foster Ave (24) | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 40u.i. DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 50 min. | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, Farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE JACK C. COLLINS | | EXAMINER'S NAME (Type) | | DATE SIGNED 8-13-57 | |
| 22a. BURIAL, Cremation BURNING | | 22b. DATE THEREOF 8/14/59 | | 22c. NAME OF CEMETERY OR CREMATORIAL OAK LAWN | |
| 23. FUNERAL DIRECTOR'S SIGNATURE EARL B. WELVERTON FUNERAL HOME INC | | ADDRESS 6306 - Belair Rd - Baltimore - 6 - Md. | | 24a. REC'D BY REGISTRAR DATE AUG 14 '59 | |
| VS. A15ME SM 2-57 | | | | 24b. REGISTRAR'S SIGNATURE Arthur S. Knob | |



10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

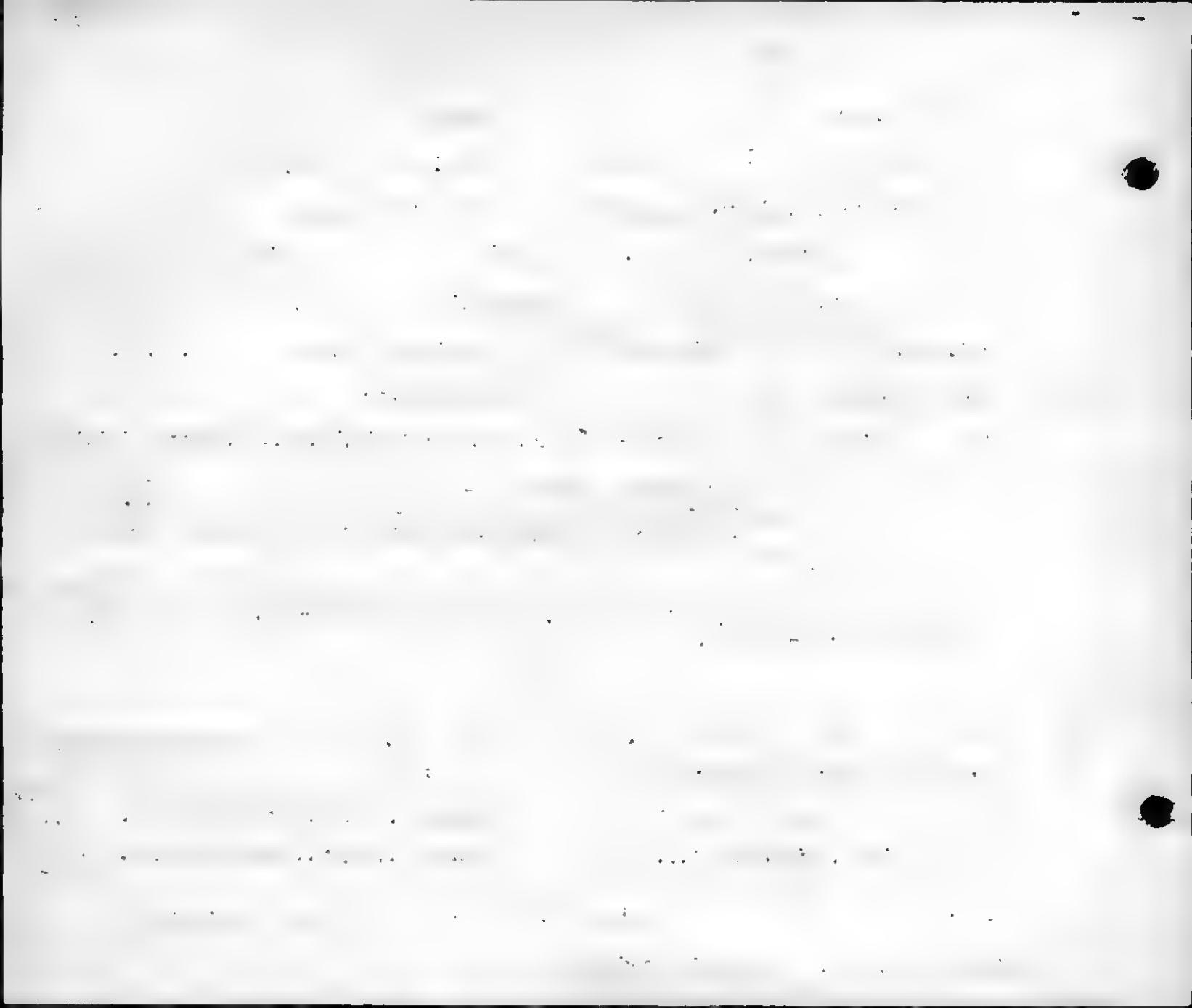
8859

CERTIFICATE OF DEATH

Reg. Dist. No.

08828

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard | | c. LENGTH OF STAY IN 1b 41 Days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | First GEORGE | Middle F. | Last MATTHEWS |
| 4. DATE OF DEATH | Month August | Day 26 | Year 1959 |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 25, 1896 |
| 9. AGE (In years last birthday) 63 | 10. IF UNDER 1 YEAR Months 0 | 11. IF UNDER 24 HRS. Days 0 | 12. IF UNDER 24 HRS. Hours 0 |
| 10a. US/AL OCCUPATION (Give kind of work done during most of working life, even if retired) Projectionist | 10b. KIND OF BUSINESS OR INDUSTRY Camera Motion Picture | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | 12. CITIZEN OF WHAT COUNTRY? U. S. A. |
| 13. FATHER'S NAME Conrad Matthews | 14. MOTHER'S MAIDEN NAME Amelia Carter | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | 16. SOCIAL SECURITY NO 68-01-1274 | INFORMANT Clin. Rec. VAH: , Balto. 18, Md., Ft. Howard Division | Address |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHIOGENIC CARCINOMA - OLD | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause, if any. XXX | | | |
| INTERVAL BETWEEN ONSET AND DEATH UNKNOWN | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CORONARY ARTERIOSCLEROSIS, MARKED-OLD. MYOCARDIAL SCARRING-OLD. | | | |
| PART III. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | |
| 20c. TIME OF INJURY Hour o. m. p. m. 19 | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.) VA | (County) (State) |
| 21. I certify that VA attended the deceased from July 14, 1959 to August 26, 1959 and that I last saw the deceased XXXXXX and that death occurred at 3:15 P.M. from the causes and on the date stated above | ADDRESS (Street, city or town, state) | DATE SIGNED 5/27/59 | |
| ACTUAL SIGNATURE John W. Crawford | M.D. VAH, BALTO., 18, MD., FORT HOWARD DIV. | 8/27/59 | |
| PHYSICIAN'S NAME (Type) | VAH, BALTO., 18, MD., FORT HOWARD DIV. 8/27/59 | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 8-21-59 | 22c. NAME OF CEMETERY OR CREMATORIUM Baltimore National Cem | 22d. LOCATION (City, town, or county) (State) Baltimore, Maryland |
| 23. FUNERAL DIRECTOR'S SIGNATURE Dippel Bros., Inc. 7110 Belair Road, Balto., Md. | ADDRESS | 24a. REC'D BY REGISTRAR DATE AUG 28 '59 | 24b. REGISTRAR'S SIGNATURE Clifford & Hause |



| MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 | | | | | | | | | | Reg. Dist. No. 08829 | |
|--|--|----------------------------------|--|---|---|---|---|---|--|--|--|
| 8860 CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catoonsville | | | c. LENGTH OF STAY IN lb 2mth29dys | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena, Maryland | | | d. STREET ADDRESS Garden and Carroll Roads | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) | | First Joseph | Middle Matulitus | Lost | 4. DATE OF DEATH | Month August | Day 7 | Year 19 59 | | | |
| 5. SEX male | | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH February 3, 1883 | | 9. AGE (In years (ptl birthday) yrs 76 | 10. IF UNDER 1 YEAR Months | 11. IF UNDER 24 HRS Days | 12. IF UNDER 24 HRS Hours | 13. CITIZEN OF WHAT COUNTRY Lithuania | 14. CITIZEN OF WHAT COUNTRY Lithuania |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | 11. BIRTHPLACE (State or foreign country) Lithuania | | | 12. CITIZEN OF WHAT COUNTRY Lithuania | | |
| 13. FATHER'S NAME Unknown | | | 14. MOTHER'S MAIDEN NAME Unknown | | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown | | | 16. SOCIAL SECURITY NO. 164-20-8043 | | | 17. INFORMANT Records: SPRING GROVE STATE HOSPITAL | | | Address | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> Coronary artery disease with poss. infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Arteriosclerotic cardiovascular disease DUE TO (c) | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | |
| 21. I certify that I attended the deceased from May 8, 1959, to August 7, 1959, that I last saw the deceased alive on August 7, 1959, and that death occurred at 9:30a M, from the causes and on the date stated above. | | | | | | | | | | ADDRESS (Street, city or town, state) DATE SIGNED Stella Wachler 8-7-59 | |
| ACTUAL SIGNATURE | | M.D. SPRING GROVE STATE HOSPITAL | | | | | | | | | |
| PHYSICIAN'S NAME (Type) | | Stella Wachler, M. D. | | | | | | | | Catonsville 28, Maryland | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 8/11/59 | | 22c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill Cemetery | | 22d. LOCATION (City, town, or county) Baltimore, Md. | | (State) | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Charles W. Lachman | | ADDRESS 637 Wash. Blvd. | | 24a. REC'D BY REGISTRAR DATE AUG 10 '59 | | 24b. REGISTRAR'S SIGNATURE Charles S. Kraus | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit Permit. Then please remove carbon paper. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8766 CERTIFICATE OF DEATH

Reg. Dist. No. 08830

| | | | |
|--|-------------------------------|---|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY BALTIMORE | | 2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RELAY | | c. LENGTH OF STAY IN 1b 1 yrs. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5025 HAZEL AVE | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) BERNARD | | First J | Middle McNamee |
| 4. DATE OF DEATH AUGUST 30 1959 | | Month August | Day 30 |
| 5. SEX MALE | 6. COLOR OR RACE U1 | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH MY 8-1825 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RAILITE COTTON | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 10c. BIRTHPLACE (State or foreign country) MARYLAND | | 11. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME PATRICK J. McNAMEE | | 14. MOTHER'S MAIDEN NAME MARIA O'KEEFE | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or, unknown) No | | 16. SOCIAL SECURITY NO. 47-05-847 | |
| 17. INFORMANT ANNIE M. McNAMEE 5025 HAZEL AVE | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure DUE TO 47-1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause, lost. (b) DUE TO Arteriosclerosis Cardiac Vascula Disease (c) Also Rheumatic Heart Disease | |
| 19. INTERVAL BETWEEN ONSET AND DEATH | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Rheumatism Arthritis Severe | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) factory, office bldg., etc. | | 20f. (City or town) (County) Baltimore (State) Md. | |
| 21. I certify that I attended the deceased from 7/1 1957 to 8/30 1957 that I last saw the deceased alive on 8/16 1957 , and that death occurred at Baltimore M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE J. N. Frederick | | ADDRESS (Street, city or town, state) 1305 Locust Ave. Baltimore, Md. | |
| PHYSICIAN'S NAME (Type) J. N. Frederick MD | | DATE SIGNED 8/3/59 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 9-2-1959 | |
| 22c. NAME OF CEMETERY OR CEMETORY Woodlawn | | 22d. LOCATION (City, town, or county) Baltimore | |
| 23. FUNERAL DIRECTOR'S SIGNATURE J. Howard Strong 320-7000-8044 | | 24a. REC'D BY REGISTRAR DATE SEP 1 '59 | |
| ADDRESS 1015 E. Pratt St. | | 24b. REGISTRAR'S SIGNATURE Orion L. Kraus | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
X

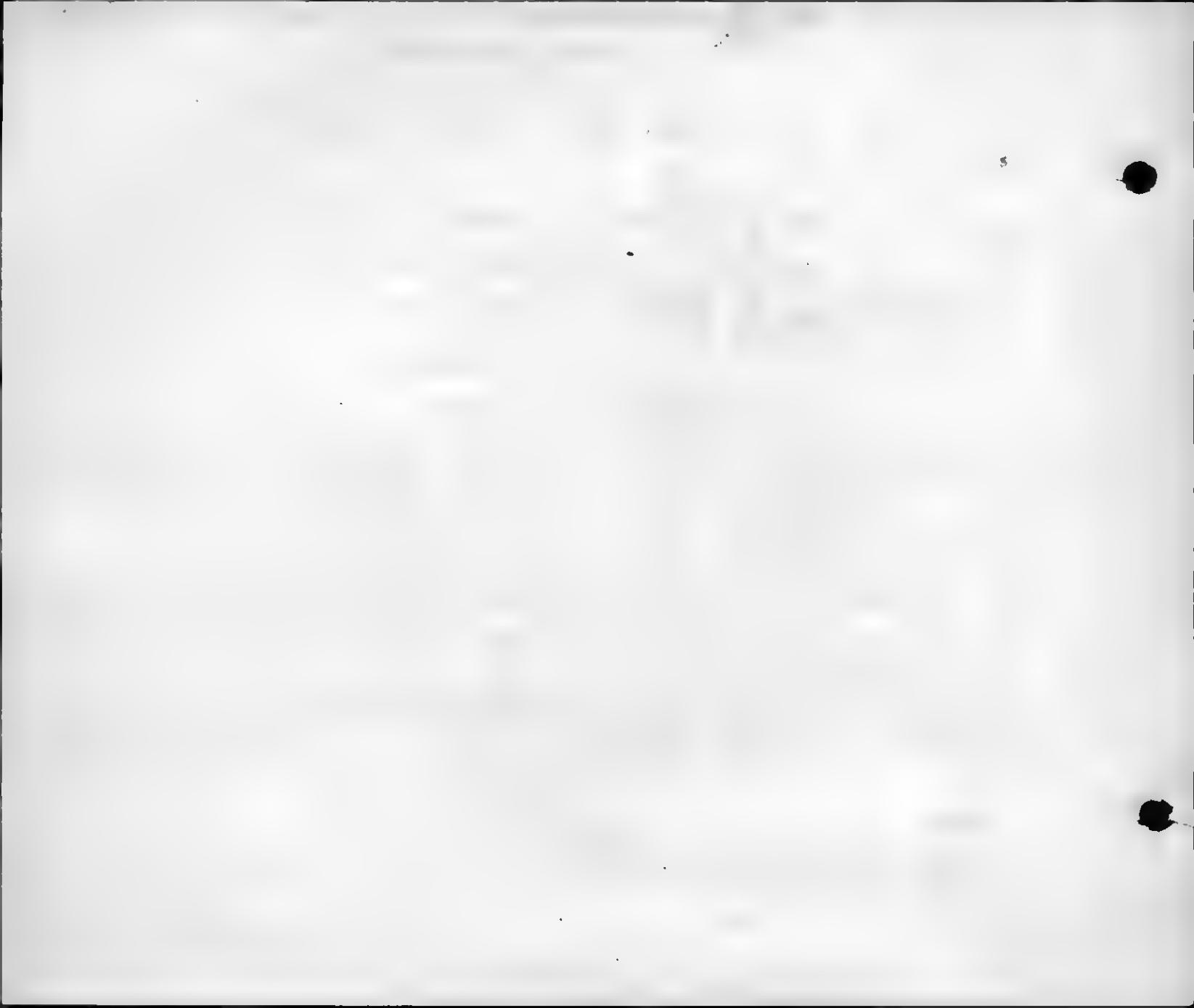
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8861 CERTIFICATE OF DEATH

18831

Reg. Dist. No.

| | | | | | | | | | |
|---|--|--|---|--|---|---|---|-------------------------------|----------------|
| 1. PLACE OF DEATH a. COUNTY BALTO. | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MD. | | b. COUNTY BALTO. | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) STONELEIGH | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) STONELEIGH | | d. STREET ADDRESS 909 GREENLEIGH RD | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 909 GREENLEIGH RD | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) MAUD | | First | Middle | 4. DATE OF DEATH E. McMULLEN | | Month | Day | Year | |
| 5. SEX F | | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH JAN. 21, 1881 | | 9. AGE (in years last birthday) 78 yrs | 10. IF UNDER 1 YEAR Months | 11. IF UNDER 24 HRS. Hours | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10b. KIND OF BUSINESS OR INDUSTRY OWN HOME | | 11. BIRTHPLACE (State or foreign country) N.H. | | 12. CITIZEN OF WHAT COUNTRY U.S. | | | |
| 13. FATHER'S NAME GATES W. HODGON | | 14. MOTHER'S MAIDEN NAME ELLEN COLBATH | | | | Address | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. — | | 17. INFORMANT JOHN G. McMULLEN | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 155.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) | | | |
| | | | | | | INTERVAL BETWEEN ONSET AND DEATH 6 months | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Hour a. m. p. m. | | Month 19 | Day | Year | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) Loch Raven Shop. Cr. | (County) Baltimore | (State) Md. |
| 21. I certify that I attended the deceased from alive on | | JUNE, 1957, to 31 Aug, 1959, that I last saw the deceased 30 Aug, 1959, and that death occurred at M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE JOHN B. DE O'HOFF | | ADDRESS (Street, city or town, state) Loch Raven Shop. Cr. Baltimore | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 9-2-59 | 22c. NAME OF CEMETERY OR CREMATORIUM FARMINGTON | | | 22d. LOCATION (City, town, or county) FARMINGTON | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE H. W. JENKINS & SONS CO. | | ADDRESS 4905 YORK RD. | 24a. REC'D BY REGISTRAR DATE SEP 1 '59 | | | 24b. REGISTRAR'S SIGNATURE Arling & Times | | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8862

CERTIFICATE OF DEATH

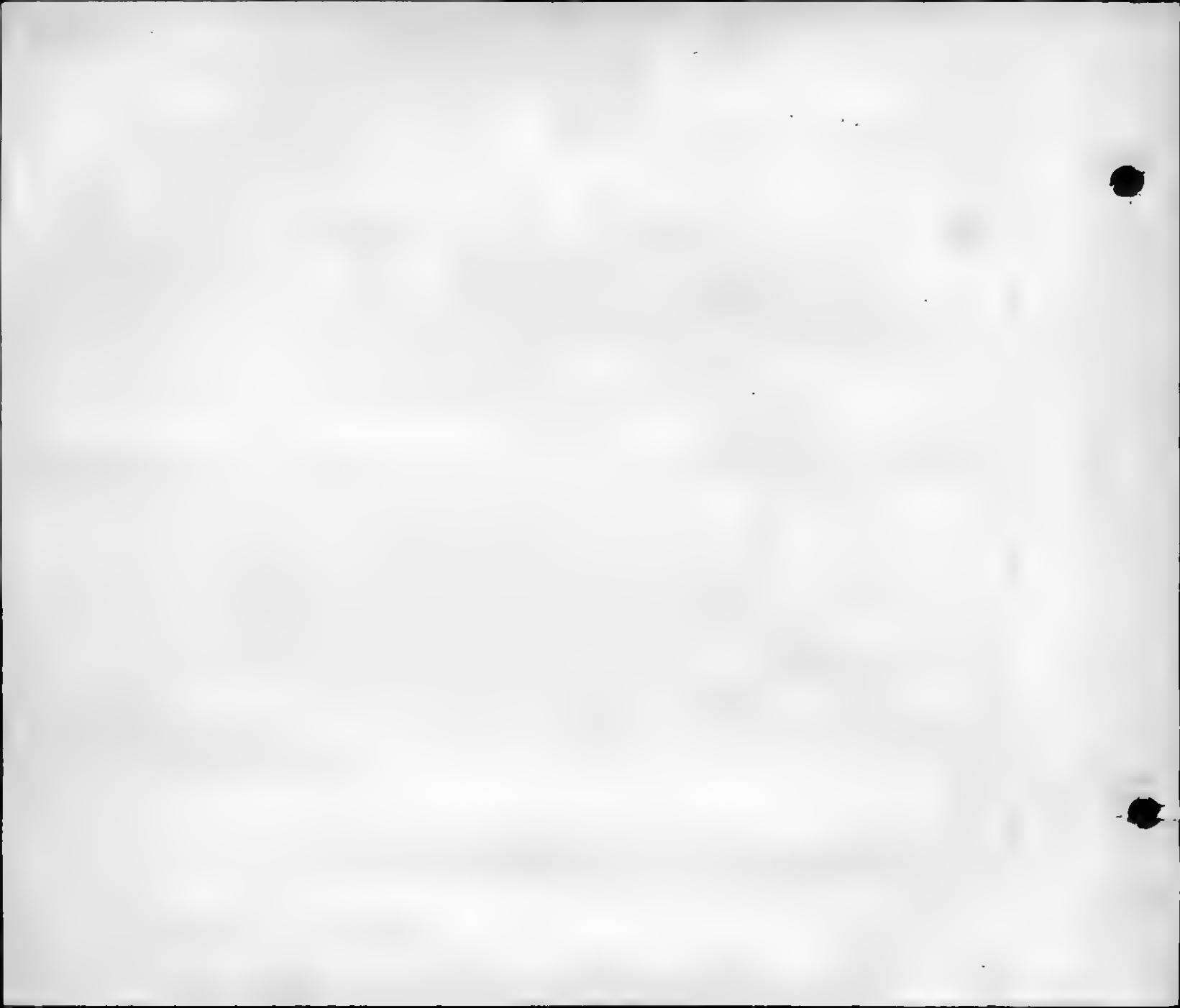
Reg. Dist. No.

08832

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | |
|---|------------------------------|---|--------------------------------------|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY <i>BALTO</i> | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MD.</i> | | b. COUNTY <i>BALTO</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>ESSEX</i> | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>ESSEX</i> | | d. STREET ADDRESS <i>612 DORSEY Ave</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>AT-Home</i> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) | First <i>CORA</i> | Middle <i>V.</i> | Last <i>MERRIKEN</i> | 4. DATE OF DEATH | Month <i>Aug</i> | Day <i>7</i> | Year <i>1959</i> |
| 5. SEX <i>Fe</i> | 6. COLOR OR RACE <i>W</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>3-22-1881</i> | 9. AGE (In years last birthday) yrs. <i>78</i> | 10. FUNDER 1 YEAR Months <i>7</i> | 11. IF UNDER 24 HRS. Hours <i>0</i> | 12. IF UNDER 24 HRS. Min <i>0</i> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>BALTO MD</i> | | 12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i> | |
| 13. FATHER'S NAME <i>John ELLINGSWORTH</i> | | 14. MOTHER'S MAIDEN NAME <i>ADAMS</i> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) <i>No</i> | | 16. SOCIAL SECURITY NO (If yes, give war or dates of service) | | 17. INFORMANT <i>HARRY MERRIKEN</i> | | Address <i>SAME</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>40.0</i> | | <i>Anteriori heart disease</i> | | | | <i>10 yrs.</i> | |
| Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO <i>Generalized arteriosclerosis</i> | | | | | | <i>15 yrs.</i> | |
| (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour e. m. p. m. <i>19</i> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>815 E. 21st St.</i> | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>Feb.</i> , 1957, to <i>Aug. 7</i> , 1957, that I last saw the deceased alive on <i>Aug. 7</i> , 1959, and that death occurred at <i>10:30 P.M.</i> from the causes and on the date stated above. | | | | ADDRESS (Street, city or town, state) | | DATE SIGNED <i>3/9/59</i> | |
| ACTUAL SIGNATURE <i>Robert J. Lyden</i> | | M.D. | | | | | |
| PHYSICIAN'S NAME (Type) <i>ROBERT J. LYDEN M.D.</i> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i> | | 22b. DATE THEREOF <i>8/11/59</i> | | 22c. NAME OF CEMETERY OR CREMATORIUM <i>WOODLAWN Cem</i> | | 22d. LOCATION (City, town, or county) <i>BALTO</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>John J. Connelly 418 Eastern Blvd. (21)</i> | | ADDRESS | | 24a. REC'D BY REGISTRAR DATE <i>AUG 12 '59</i> | | 24b. REGISTRAR'S SIGNATURE <i>Civins S. Kline</i> | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the signature prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8863 CERTIFICATE OF DEATH

08833

Reg. Dist. No.

1. PLACE OF DEATH
 a. COUNTY

Baltimore

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Fort Howard

c. LENGTH OF STAY IN lb
 2 days

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

Veterans Administration Hospital

3. NAME OF DECEASED
 (Type or print)

First

Middle

Last

1

MERRYMAN

Month
 August

Day
 19
 59

Year

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

9. AGE (in years
 lost birthday)

39

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Months

Days

Hours

Min

Male

White

WIDOWED DIVORCED

Aug. 28, 1919

yrs.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Electrician

10b. KIND OF BUSINESS OR INDUSTRY

Aircraft

11. BIRTHPLACE (State or foreign country)

Hampstead, Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Albert Merryman

14. MOTHER'S MAIDEN NAME

Ida A. Biles

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or Unknown)
 (If yes, give war and dates of service)

Yes

WW II

16. SOCIAL SECURITY NO.

220 07 7700

INFORMANT

Clin. Records VA Hospital, Ft. Howard, Md. Address

17. CAUSE OF DEATH

[Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a)

CHRONIC GLOMERULONEPHRITIS WITH UREMIA

INTERVAL BETWEEN
 ONSET AND DEATH

Unknown

542X

DUE TO

Conditions, if any, which
 gave rise to immediate
 cause (a), stating the under-
 lying cause last.

(b)

DUE TO

(c)

MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED?

YES NO

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
 (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
 Hour o. m. 19
 p. m.

20d. INJURY OCCURRED
 While at work Not while at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from August 7, 1959, to August 9, 1959, the date of death, and that death occurred at 4:00 AM, from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
 SIGNATURE

Conrad E. Gonzalez, M.D. VA Hospital, Ft. Howard, Md. 8/9/59

PHYSICIAN'S
 NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify)
 Burial 8/13/59

22b. DATE THEREOF
 Meadow Ridge Cemetery

22d. LOCATION (City, town, or county)
 Wash. Blvd., Elk Ridge, Md.

(State)

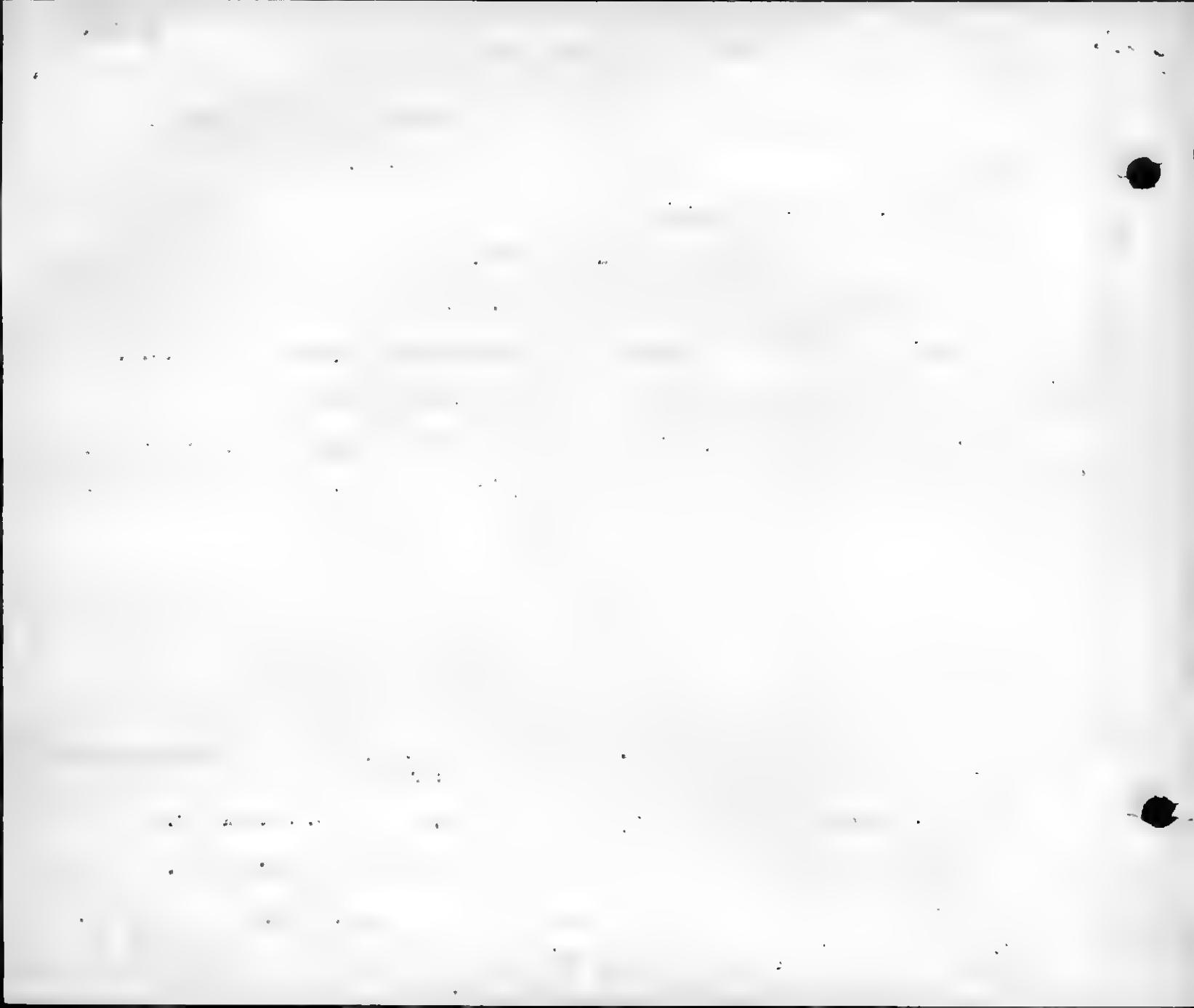
23. FUNERAL-DIRECTOR'S SIGNATURE

ADDRESS

24a. REC'D BY REGISTRAR
 DATE AUG 12 '59

24b. REGISTRAR'S SIGNATURE
 Curtis S. Kraus

Frank J. Cole, 1913 W. Balto, St., Balto., Md.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.
M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8864 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

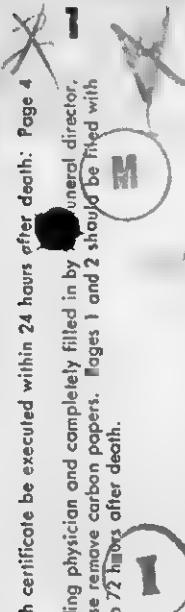
08834

Reg. Dist. No.

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE [Where deceased lived. If institution, Residence before admission] a. STATE Md. b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown | | c. LENGTH OF STAY IN 1b Reisterstown | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 528 Shirley Manor Road | | d. STREET ADDRESS 528 Shirley Manor Road | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) Allan Cleaveland Miles | | 4. DATE OF DEATH Aug. 31 1959 | Month Day Year |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Sept. 13, 1930 |
| 9. AGE (In years last birthday) 28 yrs | | 10. IF UNDER 1 YEAR Months Days | 11. IF UNDER 24 HRS Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME Clarence P. Miles | | 14. MOTHER'S MAIDEN NAME Edna Maskill | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. 216-28-5850 17. INFORMANT Mrs. Jacqueline Miles, Reisterstown, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 970.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Mental Depression | | 19. INTERVAL BETWEEN ONSET AND DEATH 24 hrs.? | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. none | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) none | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. none 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> none | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none |
| 20f. (City or town) (County) (State) | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) D. D. Caples, M. D. | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED 9-2-59 |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation | 22b. DATE THEREOF Sept. 3, 1959 | 22c. NAME OF CEMETERY OR CREMATORIUM Greenmount Cemetery | 22d. LOCATION (City, town, or county) Baltimore, Md. (State) |
| 23. FUNERAL DIRECTOR'S SIGNATURE J. P. Eline & Sons, Reisterstown, Md. | ADDRESS | 24a. REC'D BY REGISTRAR DATE SEP 3 '59 | 24b. REGISTRAR'S SIGNATURE Arthur S. French |



TO HOSPITAL OR may be retained in the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by page 3 should be detached for use as the burial-transit Permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

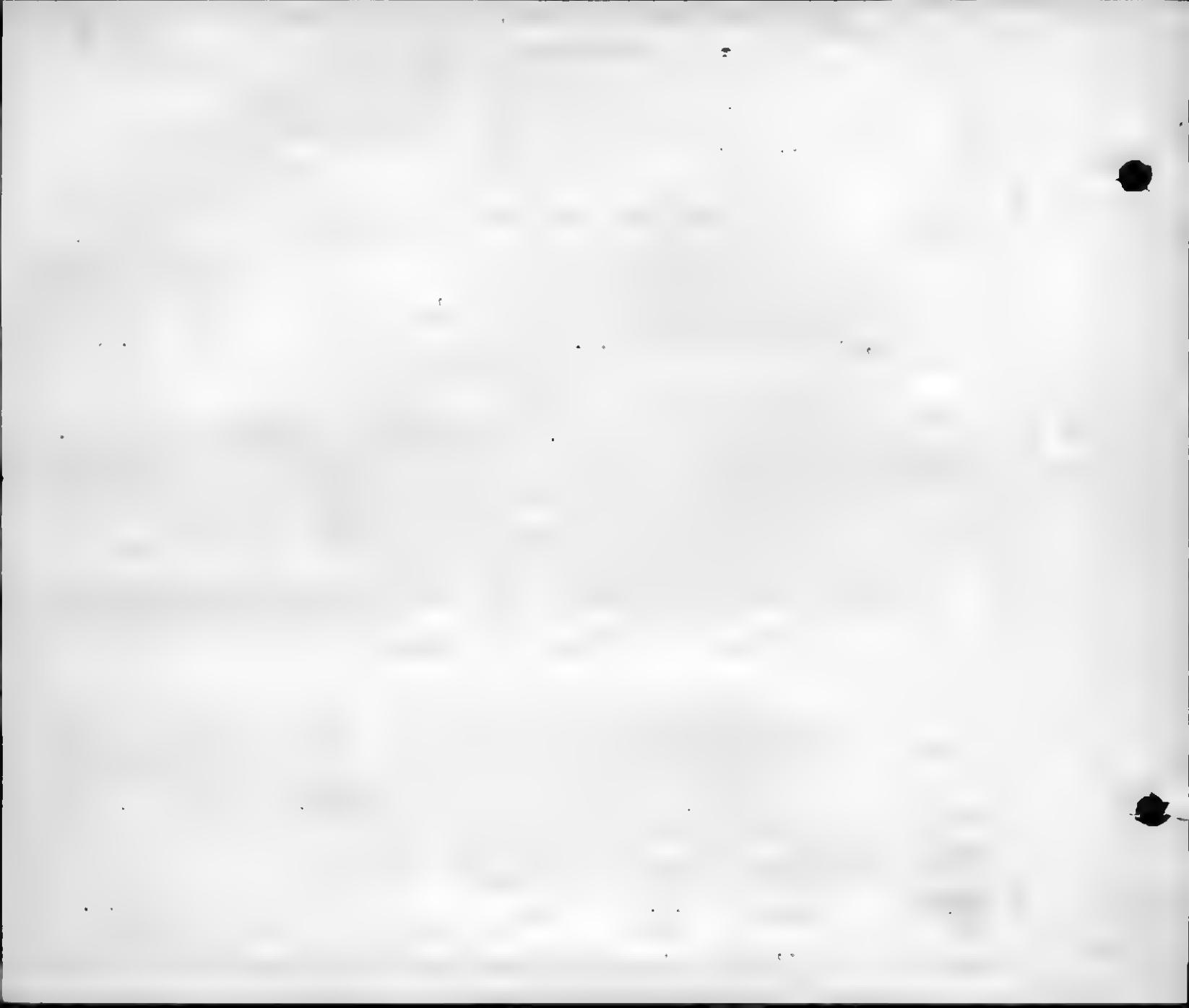
8865

CERTIFICATE OF DEATH

05835

Reg. Dist. No.

| | | | |
|--|--|--|---|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) | |
| Baltimore County MARYLAND | | b. STATE Maryland | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | |
| Catonsville 28 | | DUNDALK 22 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| Bridgeway Manor 2745 Edmondson Avenue | | e. STREET ADDRESS 2918 Dunmurry Road | |
| 3. NAME OF DECEASED (Type or print) | | First ADOLPH | Middle MISICKA |
| 4. DATE OF DEATH | | Month August | Day 26 |
| 5. SEX | | 9. AGE (In years last birthday) 91 | 10. IF UNDER 1 YEAR Months Days Hours Min. |
| MALE | | 10. COLOR OR RACE | 11. IF UNDER 24 HRS. |
| White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 12. CITIZEN OF WHAT COUNTRY? |
| WIDOWED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH April 16, 1868 | U.S.A. |
| DIVORCED <input type="checkbox"/> | | 13. FATHER'S NAME unknown | 14. MOTHER'S MAIDEN NAME unknown |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT E. June Misicka, 2918 Dunmurry Road, Balto. 22 |
| no | | none | Address |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | Catastrophic brain hemorrhage | |
| 400.1 DUE TO | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) | | Hemorrhage into the brain | |
| DUE TO | | | |
| (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, M, from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) DATE SIGNED | |
| ACTUAL SIGNATURE | | M.D. <i>Arthur S. Cook</i> | |
| PHYSICIAN'S NAME (Type) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION | | 22b. DATE THEREOF 8-29-59 | 22c. NAME OF CEMETERY OR CREMATORIUM U.S. Crematorium |
| 23. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS William Cook, Inc., 1217 St. Paul Street | 24a. REC'D BY REGISTRAR DATE AUG 28 '59 |
| | | | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Cook</i> |



TO HOSPITAL OR ENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

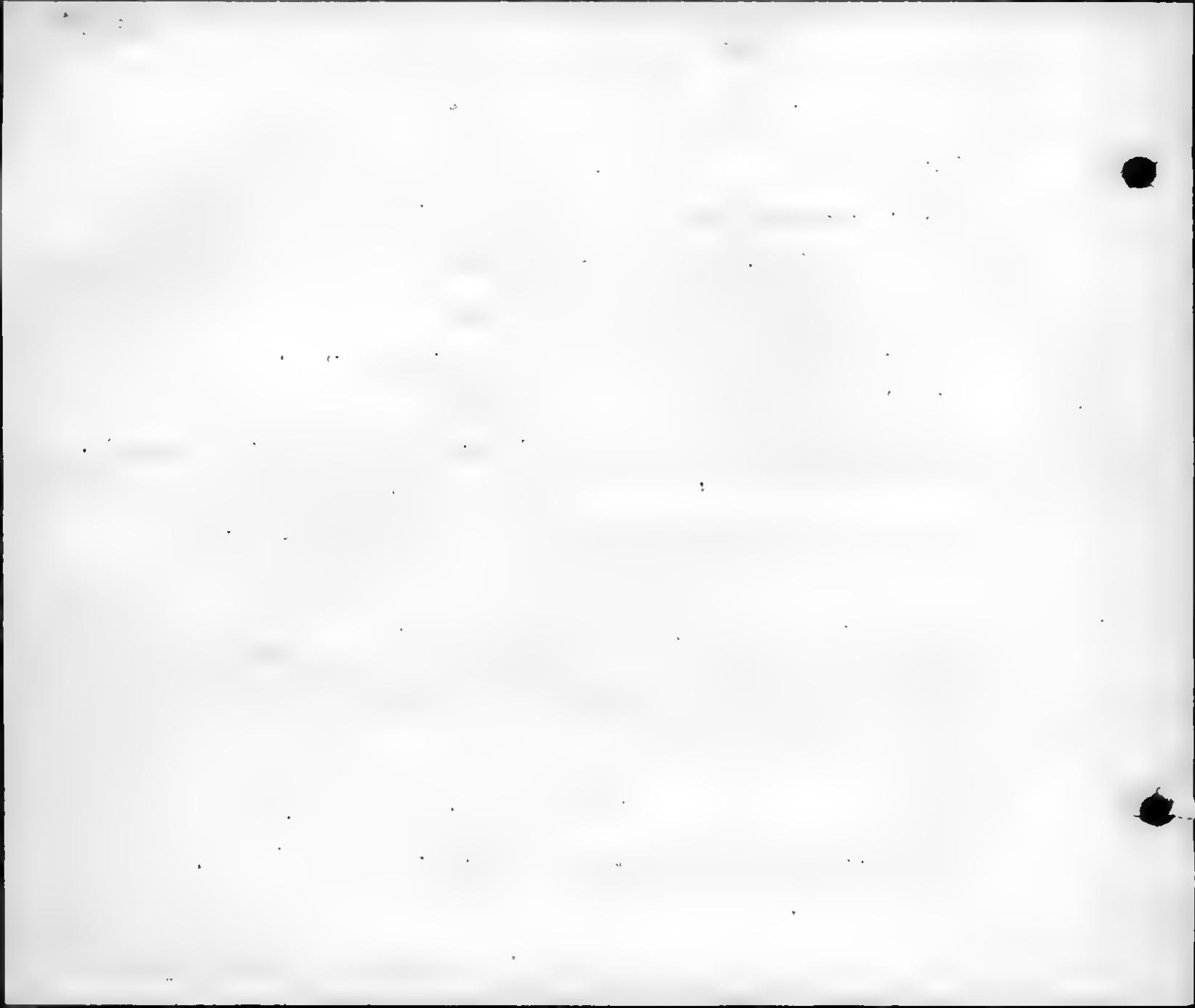
8866

CERTIFICATE OF DEATH

00836

Reg. Dist. No.

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cwings Mills | | c. LENGTH OF STAY IN lb 19 yrs. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rosewood State Training School | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Ralph | | First | Middle |
| 4. DATE OF DEATH MORTON | | Month 8 | Day 25 |
| 5. SEX Male | | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> |
| 8. DATE OF BIRTH 10/21/25 | | 9. AGE (In years lost birthday) 33 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) - - - | | 10b. KIND OF BUSINESS OR INDUSTRY - - - | |
| 11. BIRTHPLACE (State or foreign country) Friendly House, Md. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Morton, Howard | | 14. MOTHER'S MAIDEN NAME Nellie Acton | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) - - - | | 16. SOCIAL SECURITY NO. INFORMANT Rosewood records | |
| 17. MEDICAL CERTIFICATION | | Address Owings Mills, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 410 X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO Rheumatic heart disease | | INTERVAL BETWEEN ONSET AND DEATH | |
| DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 3 Buttons in bronchial tree | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at 1:35 p.m. from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) M.D. 4307 Mainfield Ave Baltimore 14, Md. | |
| ACTUAL SIGNATURE Pete W. Rieckert | | DATE SIGNED 4-26-51 | |
| PHYSICIAN'S NAME (Type) J.F. Eline & Sons | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Aug. 27/59 | |
| 22c. NAME OF CEMETERY OR CREMATORIUM Rosewood Cemetery | | 22d. LOCATION (City, town, or county) Owings Mills | |
| 23. FUNERAL DIRECTOR'S SIGNATURE J.F. Eline & Sons | | ADDRESS Reisterstown, Md. | |
| 24a. REC'D BY REGISTRAR DATE Aug. 31 '59 | | 24b. REGISTRAR'S SIGNATURE C. E. Eline | |



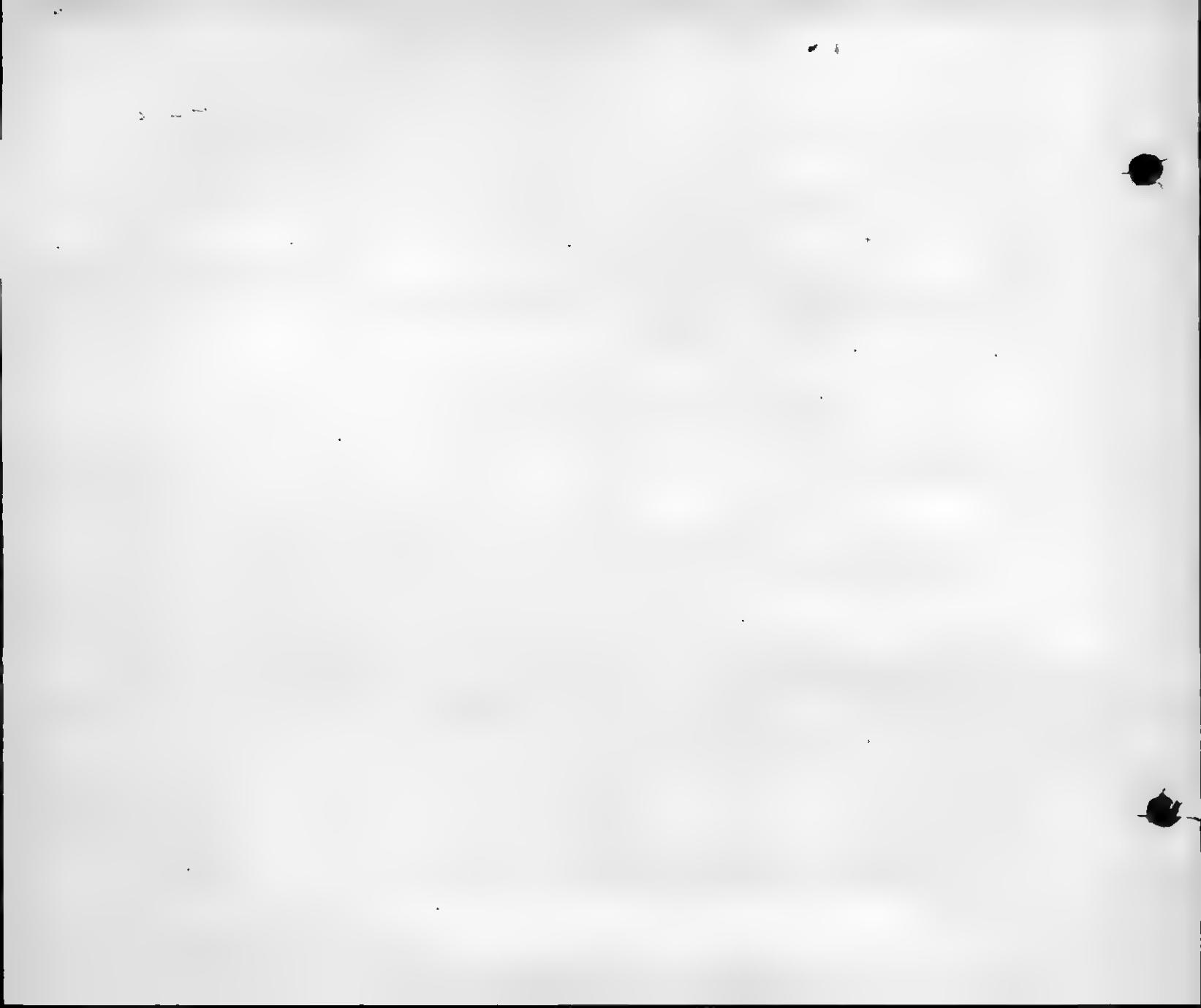
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8867 CERTIFICATE OF DEATH

08837

Reg. Dist. No.

TO HOSPITAL OR DENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY BALTIMORE | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ESSEX | | c. LENGTH OF STAY IN 1b 6 MOS. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 803 S. MARLYN AVE. (21) | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ESSEX | |
| d. STREET ADDRESS 803 S. MARLYN AVE. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | First ELIZABETH | Middle MOSLEY | 4. DATE OF DEATH AUG 27 1959 |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 7-4-84 |
| 9. AGE (in years last birthday) 75 yrs | | 10. IF UNDER 1 YEAR Months 0 Days 0 | 11. IF UNDER 24 HRS Hours 0 Min 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10b. KIND OF BUSINESS OR INDUSTRY — | |
| 10c. BIRTHPLACE (State or foreign country) N. CAROLINA | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME ALLEN BUTLER | | 14. MOTHER'S MAIDEN NAME LYDIA STREET | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) — | | 16. SOCIAL SECURITY NO. — | |
| 17. INFORMANT THOMAS MOSLEY 803 S. MARLYN AVE. | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] Address | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X | | Cerebral vascular accident INTERVAL BETWEEN ONSET AND DEATH 1 day | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. — | | Diseases, if any, which contributed to death but did not cause it. Arteriosclerotic arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 10 years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes mellitus | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) — | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. — | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Aug 27, 1959 to Aug 27, 1959 , that I last saw the deceased alive on Aug 27, 1959 , and that death occurred at 10 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. 2608 BREMSE DATE SIGNED 1/26/59 | | | |
| ACTUAL SIGNATURE Louis Semenoff | | | |
| PHYSICIAN'S NAME (Type) Louis SEMENOFF BALTIMORE MD | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 8/28/59 | |
| 22c. NAME OF CEMETERY OR CREMATORIAL BUTLER CEM. MITCHELL CO. N.C. | | 22d. LOCATION (City, town, or county) (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE John G. Connally 418 Eastern Blvd. | | 24a. REC'D BY REGISTRAR DATE SEP 1 1959 | |
| ADDRESS John G. Connally 418 Eastern Blvd. | | 24b. REGISTRAR'S SIGNATURE John G. Connally | |



TO HOSPITAL OR ENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8868

CERTIFICATE OF DEATH

08838

Reg. Dist. No.

| | | | | | | | | |
|---|--|---|---|---|---|-----------------------------------|-----------------------|----------------|
| 1. PLACE OF DEATH a. COUNTY Baltimore | MARYLAND | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland | b. COUNTY Baltimore | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural: Towson | c. LENGTH OF STAY IN 1b 13 days | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 401 Long Island Ave | d. STREET ADDRESS Balto 29 Mil | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eudowood Sanatorium | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | |
| 3. NAME OF DECEASED (Type or print) MARGARET-Ann-MURRAY | First | Middle | 4. DATE OF DEATH 8 | Month 8 | Day 17 | Year 1959 | | |
| 5. SEX F | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH Sept 4 1930 | 9. AGE (In years last birthday) 28 yrs. | 10. IF UNDER 1 YEAR Months 0 | 11. IF UNDER 24 HRS Hours 0 | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Wilkes-Barre Pa | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | |
| 13. FATHER'S NAME Joseph Murray | 14. MOTHER'S MAIDEN NAME Margaret Thomas | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) None | 16. SOCIAL SECURITY NO. | 17. INFORMANT Personal History Address Hospital Records, Eudowood Sanatorium | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY (IMMEDIATE CAUSE (a)) 526X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) none | | | | INTERVAL BETWEEN ONSET AND DEATH 15 years | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 20c. TIME OF INJURY Hour o. m. p. m. | Month 19 | Day | Year | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) Baltimore | (County) Baltimore | (State) Md. |
| 21. I certify that I attended the deceased from <u>Oct</u> , 1959, to <u>Aug 17</u> , 1959, that I last saw the deceased alive on <u>Aug 17</u> , 1959, and that death occurred at 11:10 A.M. from the causes and on the date stated above | | | | ADDRESS (Street, city or town, state) Eudowood Sanatorium, Towson 4, Md. | DATE SIGNED Milton B. Kress | | | |
| ACTUAL SIGNATURE Milton B. Kress | PHYSICIAN'S NAME (Type) Milton B. Kress, M.D. | | | | | | | |
| 22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial | 22b. DATE THEREOF 8-20-59 | 22c. NAME OF CEMETERY OR CREMATORIUM Baltimore Cem. | 22d. LOCATION (City, town, or county) Balto. Md. | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE John C. Miller Inc. - 2431-35 E. Oliver St. | ADDRESS | 24a. REC'D BY REGISTRAR DATE AUG 21 '59 | 24b. REGISTRAR'S SIGNATURE Arthur S. Kress | | | | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08839

8869

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | |
|---|----------------------------------|---|--|---|---------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> | | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MARYLAND</i> | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Anneslie</i> | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Anneslie</i> | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>610 Murdock Rd</i> | | | d. STREET ADDRESS <i>610 Murdock Rd</i> | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) | First <i>VIRGINIA</i> | Middle <i>Etheridge</i> | Last <i>NEWELL</i> | 4. DATE OF DEATH Month <i>8</i> | Day <i>11</i> |
| 5. SEX <i>Female</i> | 6. COLOR OR RACE <i>WHITE</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>7/14/1886</i> | 9. AGE (In years last birthday) <i>73</i> yrs | 10. IF UNDER 1 YEAR Months Days |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | | 10b. KIND OF BUSINESS OR INDUSTRY | | |
| 11. BIRTHPLACE (State or foreign country) <i>Baltimore - Maryland</i> | | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i> | | |
| 13. FATHER'S NAME <i>William Henry Etheridge</i> | | | 14. MOTHER'S MAIDEN NAME <i>Cora R. Allen</i> | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Tell no. or unknown) <i>No</i> | | | 16. SOCIAL SECURITY NO <i>None</i> | | |
| 17. INFORMANT <i>Richard B. Newell</i> | | | Address <i>818 Hatherleigh Ct Baltimore - 12 - MD</i> | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>443X</i> | | | INTERVAL BETWEEN ONSET AND DEATH <i>1 hr</i> | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last (b) DUE TO <i>Essential Hypertension</i> | | | | | |
| (c) DUE TO <i>Arteriosclerotic C-V-Dis.</i> | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | |
| 20c. TIME OF INJURY Hour a. m. p. m. <i>19</i> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>610 Murdock Rd</i> | |
| 20f. (City or town) <i>Baltimore</i> | | (County) <i>Baltimore</i> | | (State) <i>Md.</i> | |
| 21. I certify that I attended the deceased from <i>January</i> , 19 <i>55</i> , to <i>August 11</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>August 11</i> , 19 <i>59</i> , and that death occurred at <i>1125 P.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Charles E. Carr, Jr., M.D.</i> | | | | | |
| ADDRESS (Street, city or town, state) <i>610 Murdock Rd Baltimore - 12</i> | | | | | |
| DATE SIGNED <i>Charles E. Carr, Jr., M.D.</i> | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial Aug 14/59</i> | | | 22b. DATE THEREOF <i>Aug 14/59</i> | | |
| 22c. NAME OF CEMETERY OR CREMATORIAL <i>Moreland Memorial</i> | | | 22d. LOCATION (City, town, or county) <i>Baltimore</i> | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Henry W. Jenkins Jr. 4905 York Rd</i> | | | 24a. REC'D BY REGISTRAR DATE <i>Aug 14/59</i> | | |
| ADDRESS <i>Henry W. Jenkins Jr. 4905 York Rd</i> | | | 24b. REGISTRAR'S SIGNATURE <i>Charles E. Carr, Jr., M.D.</i> | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8870

08840

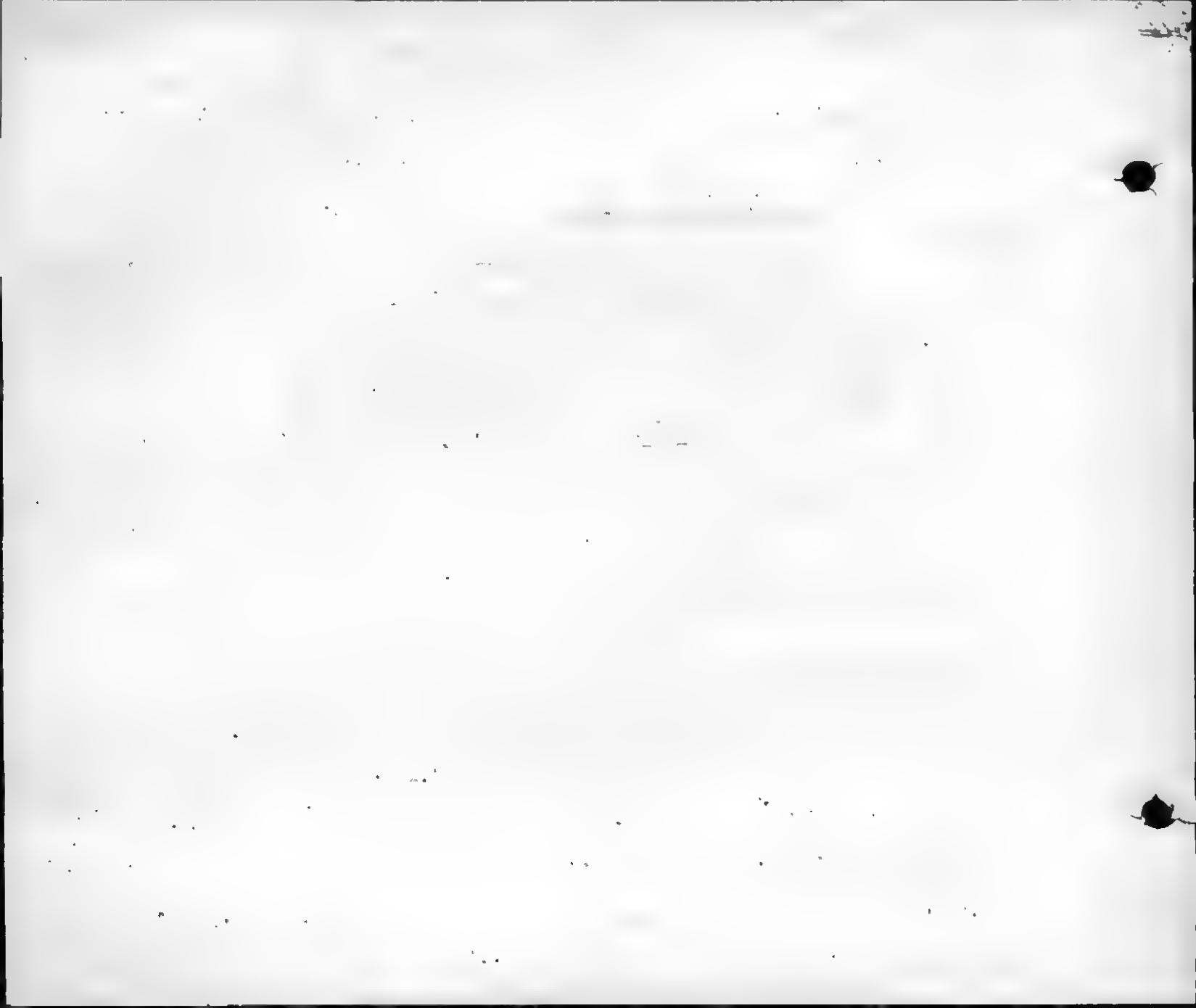
CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transmit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson | | c. LENGTH OF STAY IN 1b RURAL | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Towson Canvalescent Home 301 West Chesapeake Avenue | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Idlewyld | |
| 3. NAME OF DECEASED (Type or print) Clara | | First Clara | Middle Florence |
| 3. NAME OF DECEASED (Type or print) Clara | | Last Nickels | 4. DATE OF DEATH August 30, 1959 |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH October 13, 1886 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME Nelson Frederick | | 14. MOTHER'S MAIDEN NAME Margaretta Garrett | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. 213-31-5298A | |
| 16. SOCIAL SECURITY NO. | | INFORMANT Richard F. Nickels | Address 6301 Banbury Road |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] | | | |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) | | | |
| 153.3 DUE TO NANITION | | | |
| INTERVAL BETWEEN ONSET AND DEATH 2 MONTHS | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause, if any. | | | |
| (b) DUE TO HEPATIC METASTASES, CARCINOMATOSIS 4 MONTHS | | | |
| (c) DUE TO ADENOCARCINOMA, COLON (SIGMOID) 6 MONTHS + | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 8/17/59 1959, to 8/30/59 1959, that I last saw the deceased alive on 8/26/59 1959, and that death occurred at 11:15 AM from the causes and on the date stated above. | | | |
| ADDRESS (Street, city or town, state) 25 W. Pa. Ave. DATE SIGNED 8/31/59 | | | |
| ACTUAL SIGNATURE Donald L. Somerville, M.D. | | | |
| PHYSICIAN'S NAME (Type) Donald L. Somerville, M.D. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Sept. 2, 1959 | |
| 22c. NAME OF CEMETERY OR CREMATORIUM Weisburg | | 22d. LOCATION (City, town, or county) (State) Baltimore Co., Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Burgee Funeral Home | | ADDRESS 3631 Falls Road, Balto. 11 | 24a. REC'D BY REGISTRAR DATE SEP 1 '59 |
| | | | 24b. REGISTRAR'S SIGNATURE Charles & Anna |



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1a. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the funeral director.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

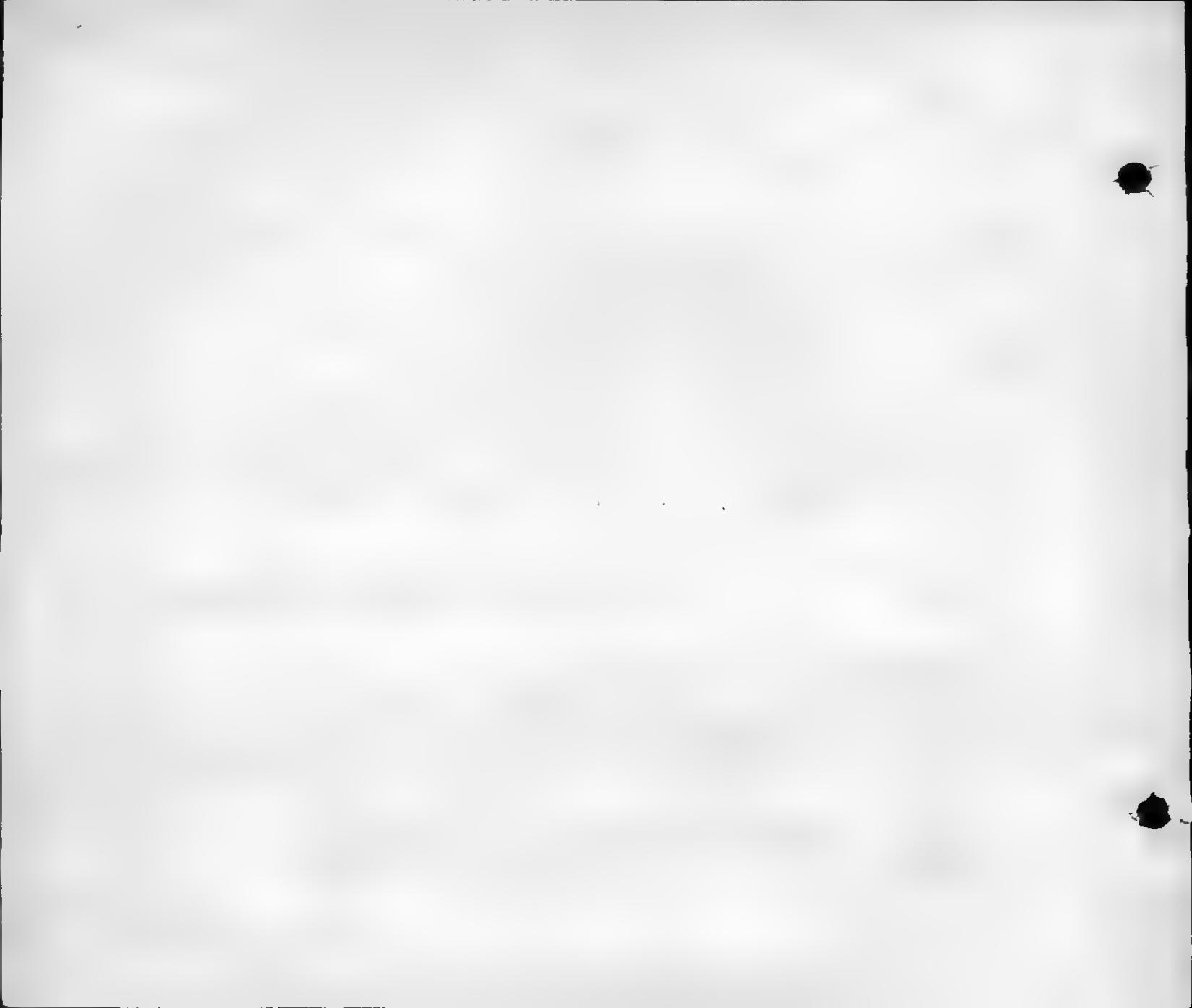
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8871 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08841

Reg. Dist. No.

| | | | | | |
|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>CHARLES CO.</u> MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE <u>MD</u> b. COUNTY <u>BALTIMORE</u> | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE, MD</u> | | | c. LENGTH OF STAY IN 1b <u>12 HOURS</u> | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CHESAPEAKE HOSPITAL</u> | | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE, MD</u> | | |
| f. STREET ADDRESS <u>604 W. FOSTER RD.</u> | | | g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) <u>HERBERT FOWLER</u> | | | 4. DATE OF DEATH Month <u>NOV</u> Day <u>11</u> Year <u>1959</u> | | |
| 5. SEX <u>M</u> | | | 6. COLOR OR RACE <u>W</u> | | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 8. DATE OF BIRTH <u>8/8/97</u> | | |
| 9. AGE (in years last birthday) <u>62 yrs.</u> | | | 10. IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u> | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>POST OFFICE</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY | | |
| 11. BIRTHPLACE (State or foreign country) <u>MD</u> | | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | |
| 13. FATHER'S NAME <u>WILLIAM T. FOWLER</u> | | | 14. MOTHER'S MAIDEN NAME <u>FOWLER</u> | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? <u>NO</u> (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. <u>W114-47-700</u> | | |
| 17. INFORMANT <u>WIFE</u> | | | Address | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | 19. INTERVAL BETWEEN ONSET AND DEATH <u>16 MIN</u> | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>174X</u> | | | DUE TO <u>ASPHYXIA</u> | | |
| Conditions, if any, which gave rise to immediate cause (b) <u>sliding the underlying cause lost</u> | | | DUE TO <u>HANGING</u> | | |
| DUE TO <u>(c)</u> | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) <u>ASPHYXIA</u> | | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u>6 a.m.</u> 19 | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | 20f. (City or town) (County) (State) | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE <u>William T. F. Fowler</u> | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | |
| EXAMINER'S NAME (Type) <u>William T. F. Fowler</u> | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | |
| | | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | |
| 22a. BURIAL, CREMATION REMOVAL (Spec.) <u>Burial</u> | | | 22b. DATE THEREOF <u>Aug 14, 1959</u> | | |
| 22c. NAME OF CEMETERY OR CREMATORIAL <u>Moreland Park</u> | | | 22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md</u> | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm Cook-Taylor, Inc., Towson, Md</u> | | | ADDRESS <u></u> | | |
| | | | 24e. REC'D BY REGISTRAR <u></u> | | |
| | | | 24f. REGISTRAR'S SIGNATURE <u>Charles E. Kline</u> | | |
| | | | DATE <u>AUG 14 '59</u> | | |



| MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 | | | | | | | | | | | | Reg. Dist. No. 06842 | |
|--|--|------------------------------------|--|--|---------------------|--|--|---|--|---|---|---|--|
| 8767 CERTIFICATE OF DEATH | | | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Montgomery</i> b. COUNTY | | | | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural</i> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Montgomery</i> | | | | | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>323 Main St.</i> | | | | d. STREET ADDRESS <i>1503 Main St.</i> | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) <i>W. E. Givleian</i> | | | | First <i>W.</i> | Middle <i>E.</i> | Last <i>Givleian</i> | 4. DATE OF DEATH <i>11/21/59</i> | Month <i>Nov.</i> | Day <i>21</i> | Year <i>1959</i> | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 5. SEX <i>Male</i> | | 6. COLOR OR RACE <i>White</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>11/21/1887</i> | | | 9. AGE (In years last birthday) " yrs <i>72 yrs</i> | 10. IF UNDER 1 YEAR Months <i>0</i> | 11. IF UNDER 24 HRS. Days <i>0</i> | Hours <i>0</i> | Min. <i>0</i> | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Businessman</i> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Business</i> | | | 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | | | 12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i> | | | |
| 13. FATHER'S NAME <i>John E. Givleian</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Constance Givleian</i> | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> | | | 16. SOCIAL SECURITY NO. <i>123-45-6789</i> | | | 17. INFORMANT <i>W. E. Givleian</i> |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>PULMONARY EDEMA</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>CEREBRAL HEMORRHAGE</i> DUE TO (c) <i>HYPERTENSION, DIABETES MELLITUS</i> | | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <i>8 DAYS</i> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>Nov. 20 1959</i> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) <i>Cliffside</i> | | (County) <i>Montgomery</i> | (State) <i>Md.</i> | | |
| 21. I certify that I attended the deceased from <i>22 August 1959</i> to <i>30 August 1959</i> that I last saw the deceased alive on <i>30 August 1959</i> , and that death occurred at <i>12:12 P.M.</i> from the causes and on the date stated above. | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>George E. Givleian M.D.</i> ADDRESS (Street, city or town, state) PHYSICIAN'S NAME (Type) <i>George E. Givleian</i> DATE SIGNED | | | | | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial 9/2/59</i> | | 22b. DATE THEREOF <i>9/2/59</i> | | 22c. NAME OF CEMETERY OR CREMATORIAL <i>Cliffside Cemetery</i> | | 22d. LOCATION (City, town, or County) <i>Cliffside</i> | | (State) <i>Md.</i> | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>George E. Givleian</i> | | | | ADDRESS <i>1503 Main St. Cliffside</i> | | | | 24a. REC'D BY REGISTRAR DATE <i>SEP 1 1959</i> | | 24b. REGISTRAR'S SIGNATURE <i>John S. Krause</i> | | | |



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the funeral director. To FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8872 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08843

Reg. Dist. No.

| | | | | | | | |
|--|--|---|---|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. | | b. COUNTY Balto. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn, Balto. 7 | | c. LENGTH OF STAY IN 16 2 mos. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn, Balto. 7 | | d. STREET ADDRESS 6841 Dogwood Rd. | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6841 Dogwood Rd. | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) Charles Earling Patterson, Sr. | | First | Middle | Lost | 4. DATE OF DEATH Aug. 24 | Month | Year 1959 |
| 5. SEX white <input type="checkbox"/> male | | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH June 30, 1908 | 9. AGE (in years last birthday) 51 | IF UNDER 1 YEAR Months 5 | IF UNDER 24 HRS Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) electrician | | 10b. KIND OF BUSINESS OR INDUSTRY Calvert Distillery | | 11. BIRTHPLACE (State or foreign country) Balto., Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Charles A. Patterson | | 14. MOTHER'S MAIDEN NAME Ida May Reilly | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. 215-01-2364 | | 17. INFORMANT Chas. E. Patterson, Jr., 715 N. Woodington Rd. | | Address Balto. 29 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | INTERVAL BETWEEN ONSET AND DEATH 30 years | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diabetes | | DUE TO | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. None | | (b) | | | | | |
| DUE TO | | (c) | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | |
| note | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. none | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE D. D. Coopler | | DATE SIGNED 8-25-59 | | | | | |
| EXAMINER'S NAME (Type) D. D. Coopler, M. D. | | M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | |
| 22a. BURIAL, CREMATION REMOVAL (Specify) Cremation | | 22b. DATE THEREOF 8-25-59 | | 22c. NAME OF CEMETERY OR CREMATORIUM London Park | | 22d. LOCATION (City, town, or county) Baltimore | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Arthur & Kline | | ADDRESS Balto. 7 | | 24a. REC'D BY REGISTRAR Arthur & Kline | | 24b. REGISTRAR'S SIGNATURE Arthur & Kline | |
| VS. A15ME SM 2/57 | | | | DATE AUG 28 '59 | | | |

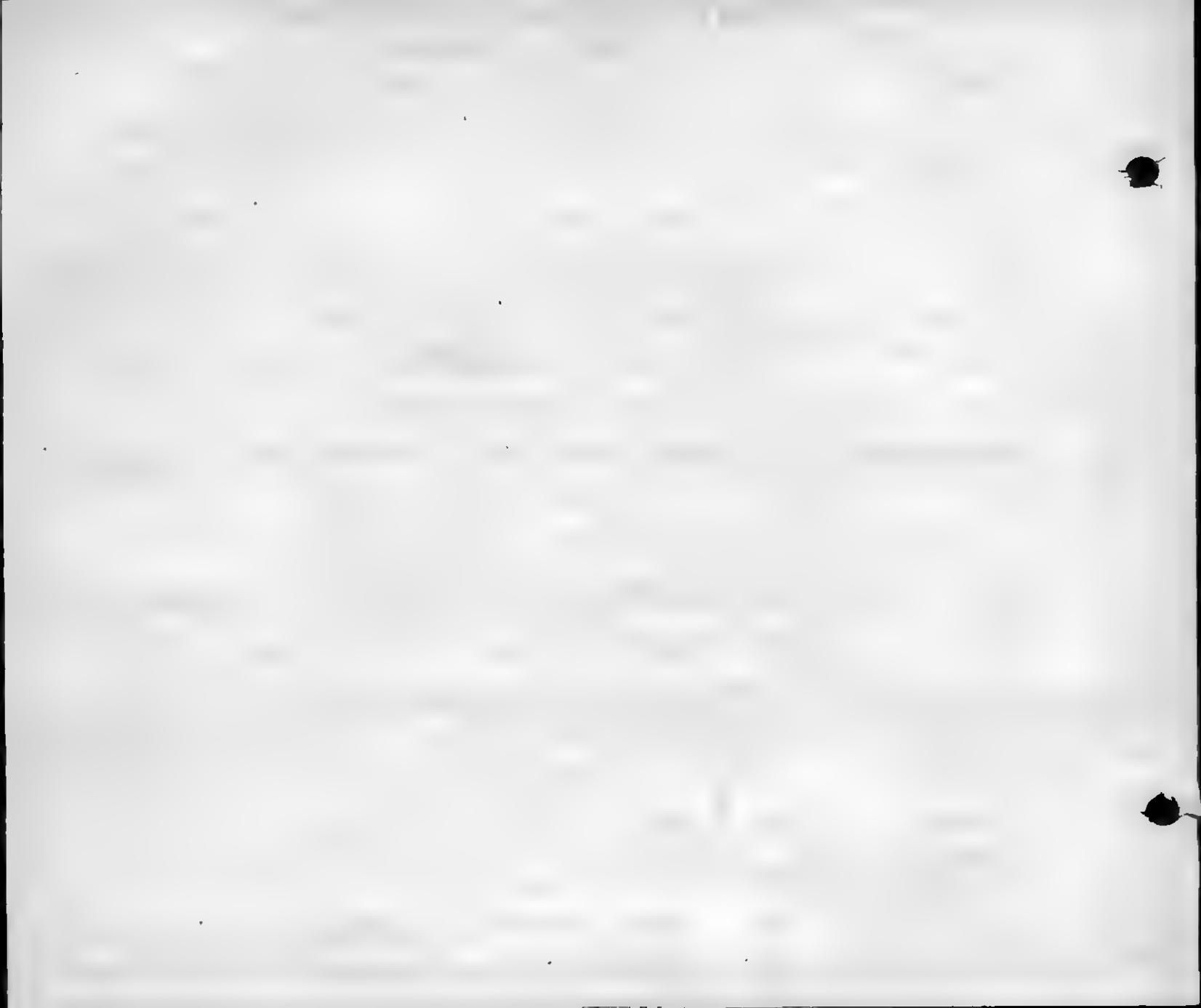


MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 06844

| | | | | | | | | | |
|---|-----------------------|---|----------------------------------|--|--------------------------------------|---|-------|--------------|---------|
| 1. PLACE OF DEATH a. COUNTY Baltimore | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. | | b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Baltimore | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Baltimore - Rural | | d. STREET ADDRESS / 2817 Delaware Ave. | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2817 Delaware Ave. | | | | d. STREET ADDRESS / 2817 Delaware Ave. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) Carrie Frances Perry | | First | Middle | Last | 4. DATE OF DEATH August 24, | Month | Day | Year 1959 | |
| S. SEX F | 6. COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Nov. 11, 194 | 9. AGE (In years last birthday) 64 yrs | IF UNDER 1 YEAR Months | IF UNDER 24 HRS Days | Hours | Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Virginia | | 12. CITIZEN OF WHAT COUNTRY? USA | | | |
| 13. FATHER'S NAME David Callis | | 14. MOTHER'S MAIDEN NAME --- Dies | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mr. E. F. Perry, Jr. 2817 Delaware Ave. | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) | | coronary Occlusion | | INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | Hypertensive Myocardial Disease | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) Baltimore | | (County) | (State) |
| 21. I certify that I attended the deceased from <u>June 15</u> , 1959, to <u>Aug. 24</u> , 1959, that I last saw the deceased alive on <u>Aug. 24</u> , 1959, and that death occurred at <u>8:30 pm</u> , from the causes and on the date stated above. | | | | | | ADDRESS (Street, city or town, state) Y. K. YUAN, M. D. 3810 S. HANOVER ST. BALTIMORE 25, MARYLAND | | DATE SIGNED | |
| ACTUAL SIGNATURE <i>Y. K. Yuan</i> | | | | | | | | | |
| PHYSICIAN'S NAME (Type) | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 8/27/59 | | 22c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Cem. | | EL - 5 22d. LOCATION (City, town, or county) Baltimore, Md. | | (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE JOHN F. DENNY, INC. | | ADDRESS 715 Light St. | | 24a. REC'D BY REGISTRAR DATE AUG 28 '59 | | 24b. REGISTRAR'S SIGNATURE Cirius S. Kraus | | | |



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

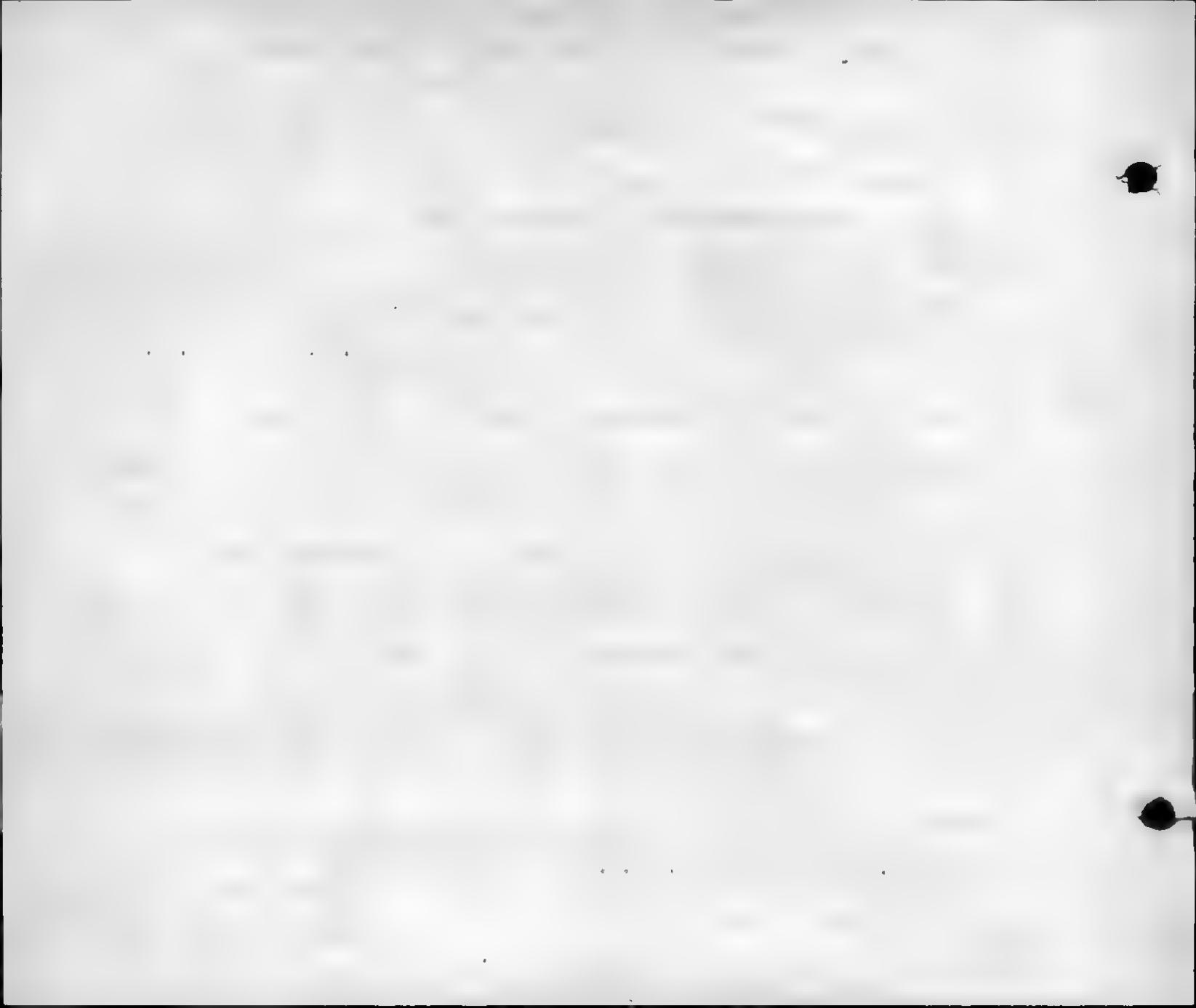
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09982

Reg. Dist. No.

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) | |
| Baltimore MARYLAND | | a. STATE Maryland | b. COUNTY Baltimore |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | c. LENGTH OF STAY IN lb | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | |
| Woodlawn | | Woodlawn | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3519 Sussex Road | | 3519 Sussex Road | |
| 3. NAME OF DECEASED (Type or print) | First Arthur | Middle | Last Randolph |
| 4. DATE OF DEATH | Month August | Day 15 | Year 19 59 |
| 5. SEX | 6. COLOR OR RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH |
| Male | White | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | July 25, 1959 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| Washington, D. C. | | U. S. A. | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | |
| | | 17. INFORMANT | |
| | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | Interstitial pneumonitis | |
| DUE TO | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | (b) | |
| DUE TO | | | |
| (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour a. m. p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 19 | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED 8/15/59 |
| EXAMINER'S NAME (Type) | W. Bradley King, Jr., M.D. | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF | 22c. NAME OF CEMETERY OR CREMATORIUM | 22d. LOCATION (City, town, or county) |
| Burial | Aug. 17, 1959 | Meadowridge Memorial | Dorsey (State) Maryland |
| 23. FUNERAL DIRECTOR'S SIGNATURE | ADDRESS | 24a. REC'D BY REGISTRAR SEP 28 '59 DATE | 24b. REGISTRAR'S SIGNATURE Loring Byers Funeral Home, 8728 Liberty Rd., |
| 9/22/59 | | | |
| Mnb | 9VVVVVVVVXVI | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08845

8875

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|---------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | c. LENGTH OF STAY IN 1b 11yr1mth15dys | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | First Anna | Middle Rasch | 4. DATE OF DEATH Month Aug. Day 18 Year 1959 |
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1890 10 JUNE |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) domestic | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Poland | | 12. CITIZEN OF WHAT COUNTRY? Poland | |
| 13. FATHER'S NAME Frank Rasch | | 14. MOTHER'S MAIDEN NAME Anna Grochmal | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown | | 16. SOCIAL SECURITY NO Unknown | |
| 17. INFORMANT Records: SPRING GROVE STATE HOSPITAL | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 44-X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH Cerebral Vascular Accident Hypertensive Cardio-Vascular Disease | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from July 30, 1959, to Aug. 18, 1959, that I last saw the deceased alive on Aug. 18, 1959, and that death occurred at 10:30 P.M., from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) | |
| ACTUAL SIGNATURE Isadore Turck, M.D. | | DATE SIGNED 8-18-59 | |
| PHYSICIAN'S NAME (Type) Isadore Turck, M.D. | | M.D. SPRING GROVE STATE HOSPITAL | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Aug 31/59 | | 22b. DATE THEREOF Holy Rosary | |
| 22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS 1930 | | 22d. LOCATION (City, town, or county) Baltimore Md | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Ozagowski Eastern | | 24a. REC'D BY REGISTRAR DATE AUG 20 '59 | |
| | | 24b. REGISTRAR'S SIGNATURE C. L. L. & T. Inc. | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8876 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

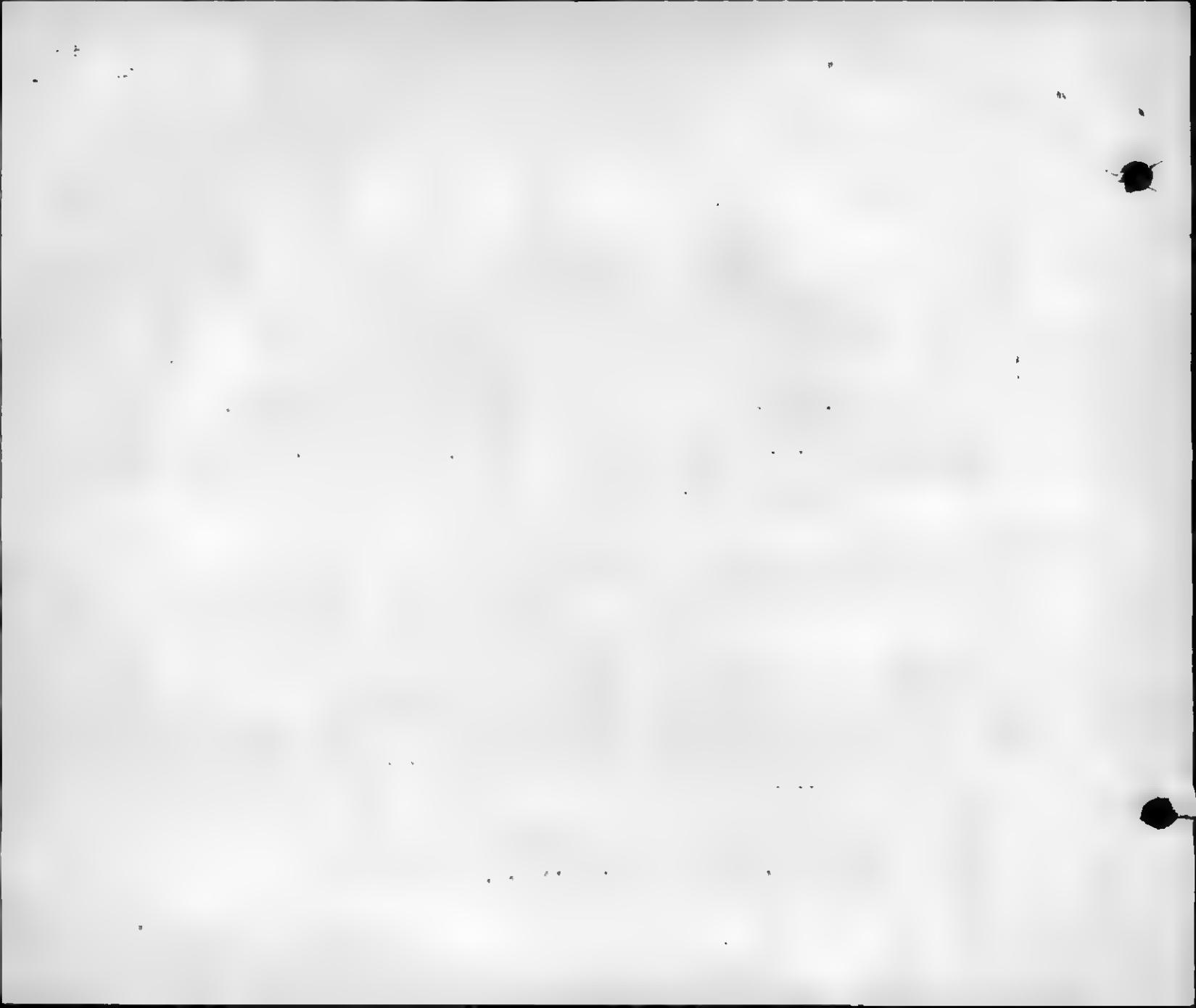
09846

Reg. Dist. No.

| | | | |
|---|---|--|---|
| 1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | | c. LENGTH OF STAY IN 1b c. LENGTH OF STAY IN 1b | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7903 Baltimore Street | | d. STREET ADDRESS 7903 Baltimore Street | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) | First CHARLES | Middle OLIVER | Last RAY |
| 4. DATE OF DEATH | Month August | Day 24 | Year 1959 |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH July 11, 1917 |
| 9. AGE (In years last birthday) 42 yrs. | 10. IF UNDER 1YEAR Months 0 Days 0 | 11. IF UNDER 24 HRS. Hours 0 Min. 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY Balto City | |
| 10c. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME Frank E. Ray. | | 14. MOTHER'S MAIDEN NAME XXXXX Annie Redman. | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO. 217 07 3315 | |
| 17. INFORMANT 2nd W.W. | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brain abscess | | INTERVAL BETWEEN ONSET AND DEATH | |
| DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b). DUE TO | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) | |
| 20c. TIME OF INJURY Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE <i>W. Bradley King, Jr.</i> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| EXAMINER'S NAME (Type) W. Bradley King, Jr., M.D. | | DATE SIGNED 8/24/59 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 8/27/59 | 22c. NAME OF CEMETERY OR CREMATORIAL Meadowridge |
| 22d. LOCATION (City, town, or county) Wash Blvd., Md. | | (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Austin E. Donovan - 3818 Poland Ave.</i> | | 24a. ADDRESS 3818 Poland Ave. | 24b. REC'D BY REGISTRAR DATE AUG 26 '59 |
| | | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i> | |

1. **NOTIFICATION:** This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

2. **TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



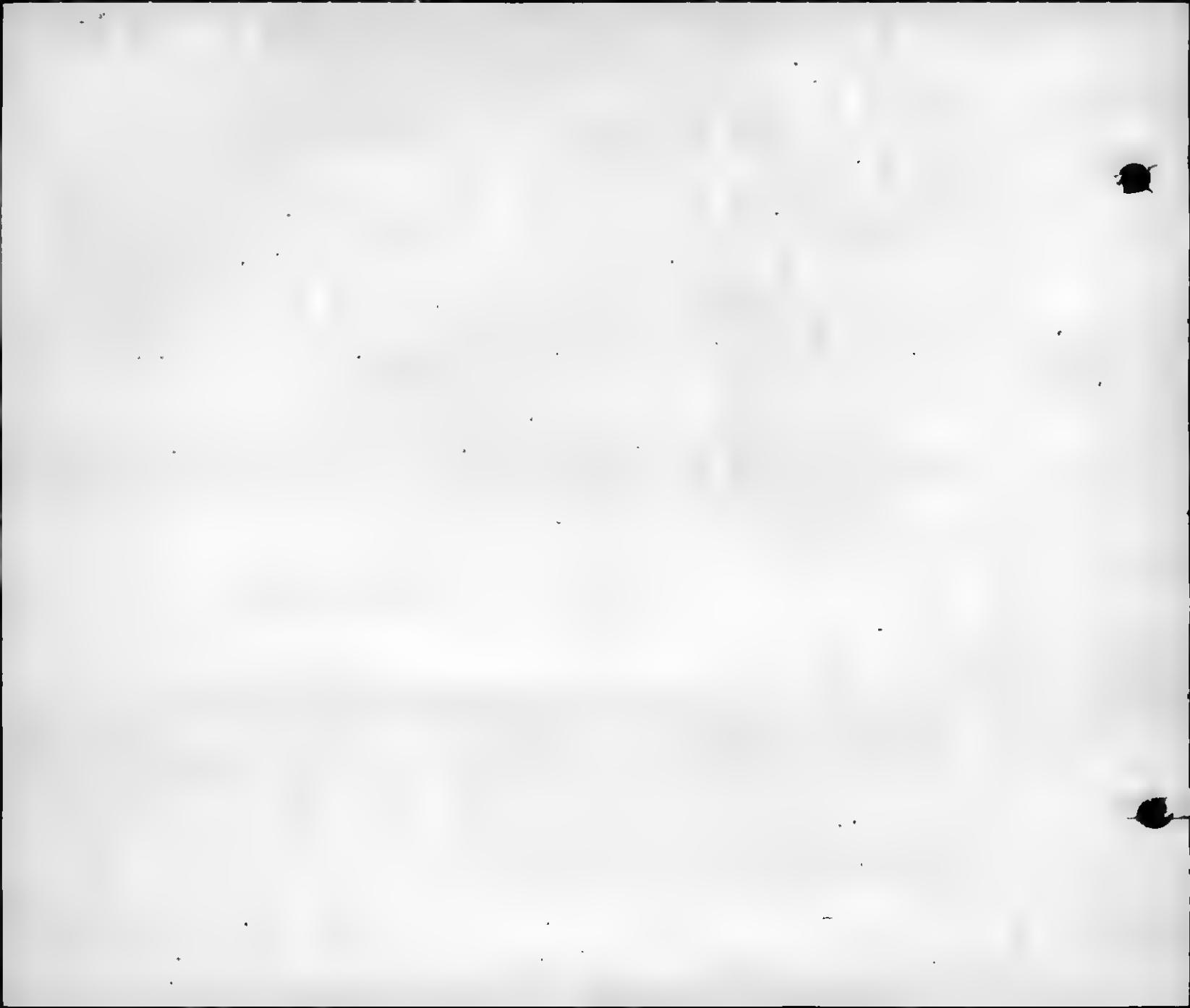
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained in the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 8847
 8877 CERTIFICATE OF DEATH

Reg. Dist. No. _____

| | | | | | | | |
|--|---------------------------|---|--|---|--|--|-----------------------------------|
| 1. PLACE OF DEATH a. COUNTY BALTIMORE | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND | | b. COUNTY BALTIMORE | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7436 KENLEA AVE. | | d. STREET ADDRESS 7436 KENLEA AVE. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) MERLE | | First E. | Middle REED | 4. DATE OF DEATH AUG. 7 1959 | Month Day Year | | |
| S. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH APRIL 16 1888 | 9. AGE (In years last birthday) 71 yrs | IF UNDER 1 YEAR Months | IF UNDER 24 HRS Days Hours Min |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WOODWORKER | | 10b. KIND OF BUSINESS OR INDUSTRY PITTSBURGH PLATE | | 11. BIRTHPLACE (State or foreign country) KENE PENNA. | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | |
| 13. FATHER'S NAME THOMAS REED | | 14. MOTHER'S MAIDEN NAME OLIVE CASPER | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO | | 16. SOCIAL SECURITY NO. 213-05-2934 | | 17. INFORMANT CLARA M. REED | | Address 7436 KENLEA AVE. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | coronary thrombosis | | | | INTERVAL BETWEEN ONSET AND DEATH 12 hrs | |
| 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) | | | | | | | |
| DUE TO (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Duodenal ulcer, esophageal varices | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) BALTO., MD. | (County) (State) |
| 21. I certify that I attended the deceased from 8 - 7 - 1959, to 8 - 7 - 1959, that I last saw the deceased alive on 8 - 7 - 1959, and that death occurred at 3:00 PM, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Santi Amoroso | | | | ADDRESS (Street, city or town, state) 6801 Belair Road, Balt. 6 | | DATE SIGNED 8-8-59 | |
| PHYSICIAN'S NAME (Type) Santi Amoroso | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 8-10-1959 | | 22c. NAME OF CEMETERY OR CREMATORIUM MORELAND CEM. | | 22d. LOCATION (City, town, or county) BALTO., MD. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Lorraine Fun'l Home | | ADDRESS 7401 Belair Rd. | | 24a. REC'D BY REGISTRAR DATE AUG 11 '59 | | 24b. REGISTRAR'S SIGNATURE Charles S. Kline | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

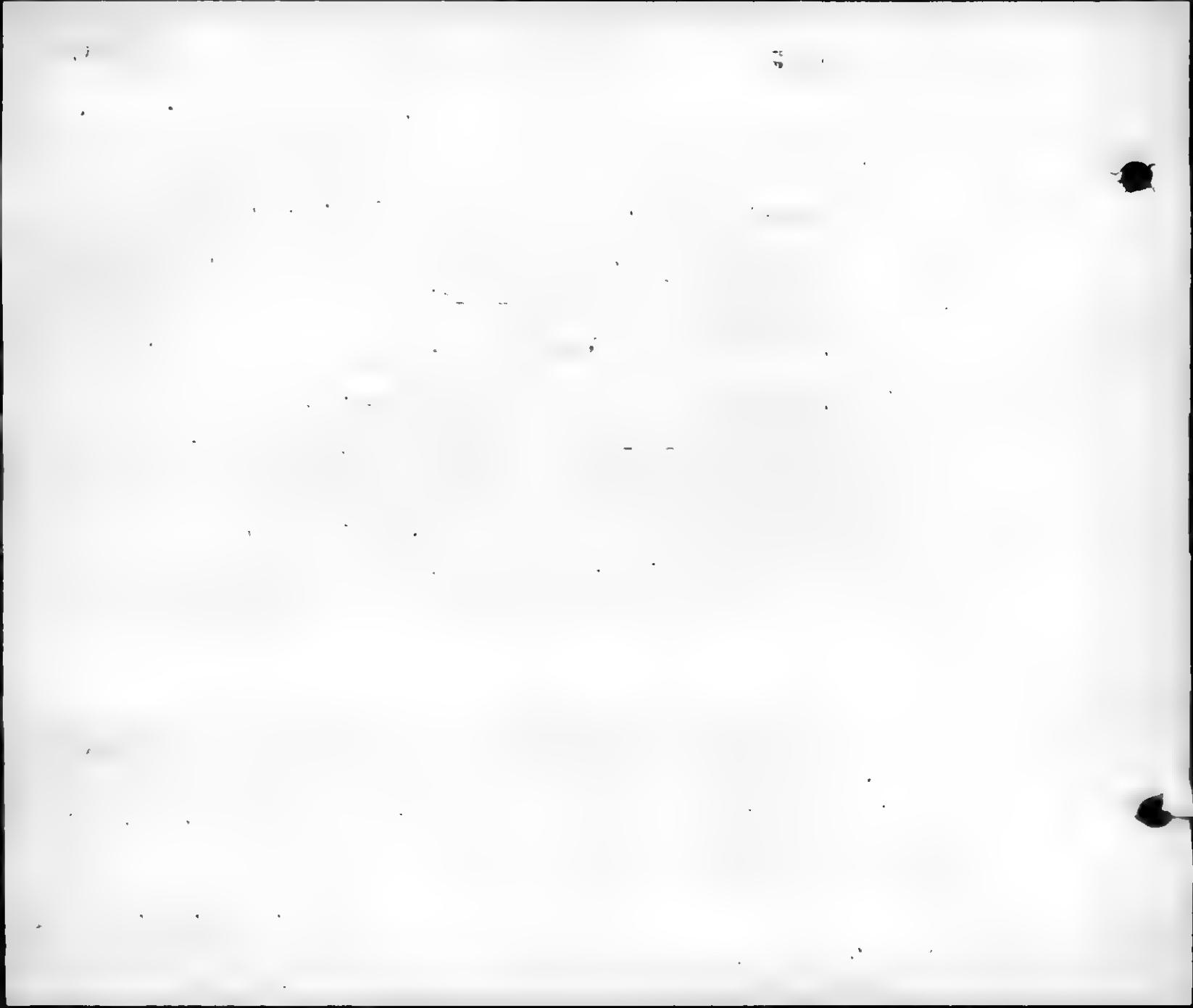
06848

8878

| | | | |
|---|-------------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Baltimore</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i> | | c. LENGTH OF STAY IN 1b <i>7-2</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>309 Ingleside Ave.</i> | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i> | |
| 3. NAME OF DECEASED (Type or print) <i>John</i> | | First <i>J.</i> | Middle <i>Reinhard</i> |
| 4. DATE OF DEATH <i>Aug. 14 1959</i> | | Month <i>Aug.</i> | Day <i>14</i> |
| 5. SEX <i>male</i> | | 6. COLOR OR RACE <i>white</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 8. DATE OF BIRTH <i>9-14-1892</i> | | 9. AGE (In years last birthday) <i>66</i> | 10. IF UNDER 1 YEAR Months <i>0</i> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>self emp.</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Nursing Home</i> | 11. BIRTHPLACE (State or foreign country) <i>Md.</i> |
| 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 13. FATHER'S NAME <i>Charles E. Reinhard</i> | |
| 14. MOTHER'S MAIDEN NAME <i>Emily Francis</i> | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> | |
| 16. SOCIAL SECURITY NO. <i>578-07-6602</i> | | 17. INFORMANT <i>Mrs Naomi Reinhard</i> | 18. ADDRESS <i>same</i> |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>33IX</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cerebral Vasculair Accident</i> (c) <i>Generalized arteriosclerosis & Cerebral arteriosclerosis</i> | | 19. INTERVAL BETWEEN ONSET AND DEATH <i>10 mos</i> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.) 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <i>Aug 10, 1958</i> to <i>Aug 14, 1959</i> that I last saw the deceased alive on <i>Aug 13, 1959</i> , and that death occurred at <i>5:45 PM</i> , from the causes and on the date stated above. | | 22. ADDRESS (Street, city or town, state) <i>Leonard Wallenstein, 878 W. 36th Baltimore</i> | |
| ACTUAL SIGNATURE <i>Leonard Wallenstein, M.D.</i> | | DATE SIGNED <i>Aug 18 1959</i> | |
| PHYSICIAN'S NAME (Type) <i>LEONARD WALLENSTEIN, M.D.</i> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | 22b. DATE THEREOF <i>8-18-59</i> | 22c. NAME OF CEMETERY OR CREMATORIAL <i>Wilson Cemetery</i> | 22d. LOCATION (City, town, or county) (State) <i>Baltimore Co. Md.</i> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i> | | 24a. ADDRESS <i>5305 Harford Rd</i> | 24b. REC'D BY REGISTRAR DATE <i>AUG 18 1959</i> |
| | | 24b. REGISTRAR'S SIGNATURE <i>Carroll S. Kraus</i> | |

TO HOSPITAL OR TENDING HOSPITAL: To require that the death certificate be executed within 24 hours
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

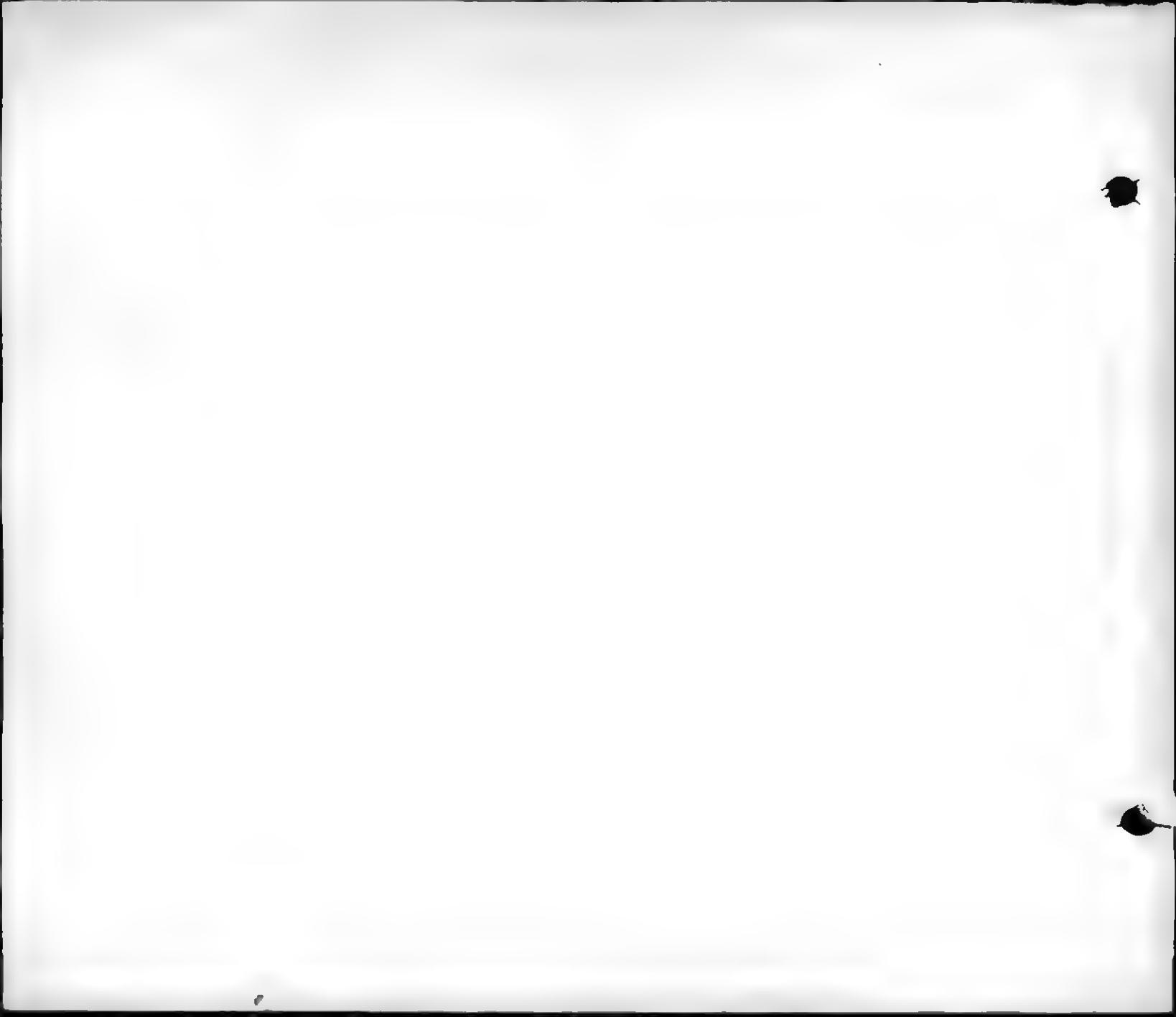


MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08849

8879 CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH 1. NAME OF DECEASED (Type or Print) | | 2. DATE OF DEATH | |
| ELLA CECILIA ROONEY | | AUG 26, 1959 | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland 217 BLENHEIM RD, 12 | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence a. STATE MARYLAND b. COUNTY BALTIMORE before admission) | |
| B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR INSTITUTION Baltimore County - Balt. - 12 | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE | |
| 4. LENGTH OF STAY IN BALTIMORE Yrs. 71 yrs Mo. 0 Days 0 | | 5. STREET ADDRESS (If rural, give location) 217 BLENHEIM RD, BALTO 12 MD | |
| 5. SEX F 6. COLOR OR RACE W 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) W, Div | | 8. DATE OF BIRTH AUG 17, 1888 71 9. AGE (In years last birthday) Months 0 Under 1 Year Days 0 Under 24 Hours Hours 0 Min. 0 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE L. T. | | 10B. KIND OF BUSINESS OR INDUSTRY | |
| 13. FATHER'S NAME DENNIS DRISCOLL | | 11. BIRTHPLACE (State or foreign country) BALTIMORE MD | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) NO | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 16. SOCIAL SECURITY NO. | | 14. MOTHER'S MAIDEN NAME CATHERINE FENTON | |
| 18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 176.0 ANTECEDENT CAUSES | | 17. INFORMANT DR. MARIUS P. JOHNSON MED. ARTS BLDG | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST | | ADDRESS 222 INTERVAL BETWEEN ONSET AND DEATH 7 days | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | CAUSE OF DEATH UREMIA | |
| IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II | | (B) DUE TO CARCINOMA OF VULVA | |
| 19A. DATE OF OPERATION APRIL 1959 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED OPERATION - VULVECTOMY APRIL 1959 - METASTASES OF CARCINOMA | |
| 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from AUG. 26 1959, that (I) (we) last saw the deceased alive on AUG. 24 1959, and that death occurred at 6:30 P.M., from the causes and on the date stated above | | 19.39 to 1959... 1959... | |
| 23A. SIGNATURE Marius P. Johnson ATTENDING PHYS. <input checked="" type="checkbox"/> M.D. <input type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 23B. ADDRESS 222 Med. Arts BLDG BALTO. 1 MD 23C. DATE SIGNED AUG 27, 1959 | |
| 24A. BURIAL, CREMA- TION, REMOVAL (Specify) BURIAL | | 24B. DATE 8/29/59 | |
| 24C. NAME OF CEMETERY OR CREMATORIAL CATHEDRAL CEM. | | 24D. LOCATION (City, town, or county) BALTO - (State) | |
| DATE RECEIVED BY LOCAL REGISTRAR S-1 | | 25. FUNERAL DIRECTOR ADDRESS Frederick J. Sen | |
| REGISTRAR'S SIGNATURE Arthur J. Smith | | | |



XIM FOR STATE HEALTH DEPT.

105850

TO DEPUTY MEET EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMQ. Page 5 may be retained by your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

105850

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | | | |
|--|--|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland | | b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | c. LENGTH OF STAY IN lb 2mth16dys | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | | d. STREET ADDRESS 1925 Linden Avenue | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) Louis | | First Middle Rosen | | 4. DATE OF DEATH August 4 1959 | | Month Day Year | | | |
| 5. SEX male | | 6. COLOR OR RACE white | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 1877 | | 9. AGE (In years last birthday) 82 yrs | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) contractor | | 10b. KIND OF BUSINESS OR INDUSTRY small bldgs. | | 11. BIRTHPLACE (State or foreign country) Russia | | 12. CITIZEN OF WHAT COUNTRY? Russia | | | |
| 13. FATHER'S NAME Unknown | | | | 14. MOTHER'S MAIDEN NAME Unknown | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. Unknown | | 17. INFORMANT Records: SPRING GROVE STATE HOSPITAL | | Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>403.7</i> DUE TO <i>Pneumonia</i> | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (b) <i>Cardio vascular disease</i> DUE TO | | | | | | | | | |
| (c) <i>Accident pasten right hip</i> | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b) | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) Shoved to the floor on 7-21-59 by another patient, sustaining frac. right femur | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20c. TIME OF INJURY Hour 305. 12:05 p.m. 7-21-59 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> of work <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital | | 20f. (City or town) Catonsville | | (County) (State) 28, Maryland | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE <i>Dr. G. M. Kieffer</i> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | DATE SIGNED 8-4-59 | |
| 22a. BURIAL, CREMATION REMOVAL (Specify) Burial | | 22b. DATE THEREOF 8-5-1959 | | 22c. NAME OF CEMETERY OR CREMATORIAL Mt Carmel | | 22d. LOCATION (City, town, or county) Baltimore | | (State) Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Jack Lewis, Inc. 2100 Eastern Place.</i> | | ADDRESS | | 24a. REC'D BY REGISTRAR AUG 6 '59 | | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i> | | | |



TO HOSPITAL OR PRACTICING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 1 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08851

8881

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|---------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | c. LENGTH OF STAY IN 1b 1 mth 7dys | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | |
| 3. NAME OF DECEASED (Type or print) John | | d. STREET ADDRESS 73 North Monastery Avenue | |
| 4. DATE OF DEATH Saum, Jr. August 25 1959 | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH January 13, 1920 |
| 9. AGE (In years last birthday) 39 yrs. | | 10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0 | 11. IF UNDER 24 HRS Hours 0 Min 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) electrician | | 10b. KIND OF BUSINESS OR INDUSTRY construction | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY U. S. A. | |
| 13. FATHER'S NAME John Saum, Sr. | | 14. MOTHER'S MAIDEN NAME Mattie Middlecamp | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Vet. no. or unknown) 33548169 | | 16. SOCIAL SECURITY NO. <u>217-09-9477</u> 17. INFORMANT Unknown | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 25X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO General paresis (c) | | 19. INTERVAL BETWEEN ONSET AND DEATH | |
| 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Aug. 22, 1959, to Aug. 25, 1959, that I last saw the deceased alive on Aug. 25, 1959, and that death occurred at 4:25a M, from the causes and on the date stated above. ACTUAL SIGNATURE <u>Stella Wachsler</u> ADDRESS (Street, city or town, state) DATE SIGNED M.D. SPRING GROVE STATE HOSPITAL 8-25-59 | | | |
| 22a. BURIAL, CREMATION, OR CREMATORIAL (Specify) Burial | | 22b. DATE THEREOF Aug 28/59 | |
| 22c. NAME OF CEMETERY OR CREMATORIAL Baltimore National | | 22d. LOCATION (City, town, or county) Baltimore | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Wiggett Funeral Home - 1300 Eutaw Pl | | 24a. REC'D. BY REGISTRAR AUG 3 1959 | |
| PHYSICIAN'S NAME (Type) Stella Wachsler, M. D. | | 24b. REGISTRAR'S SIGNATURE Cyrus S. Hause | |
| 22e. DATE REMOVAL (Specify) Burial | | 22f. (State) | |
| 24c. ADDRESS 1300 Eutaw Pl | | 24d. DATE | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08852

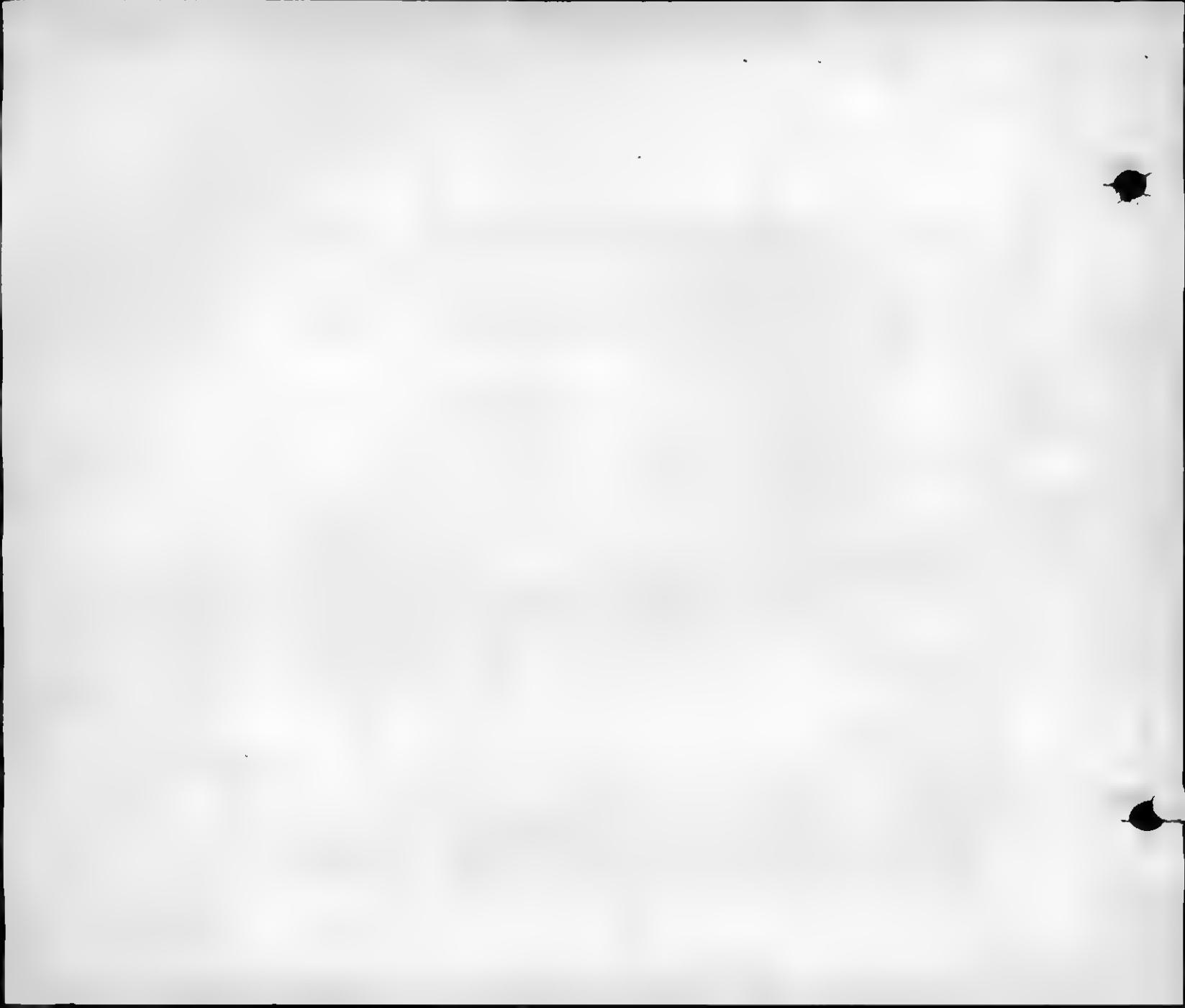
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or my designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

8882

Reg. Dist. No.

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| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE | | 3. NAME OF DECEASED (Type or print) | | 4. DATE OF DEATH | | 5. SEX Male | | 6. COLOR OR RACE H. | | 7. MARRIED NEVER MARRIED WIDOWED DIVORCED | | 8. DATE OF BIRTH 11-12-33 | | 9. AGE (In years last b. birthday) 25 yrs | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine | | 11. KIND OF BUSINESS OR INDUSTRY Steel Ind. | | 12. CITIZEN OF WHAT COUNTRY? USA | | | |
| | | | | Daniel Charles Savage. | | | | | | | | | | | | | | | | | | | | | |
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8883

CERTIFICATE OF DEATH

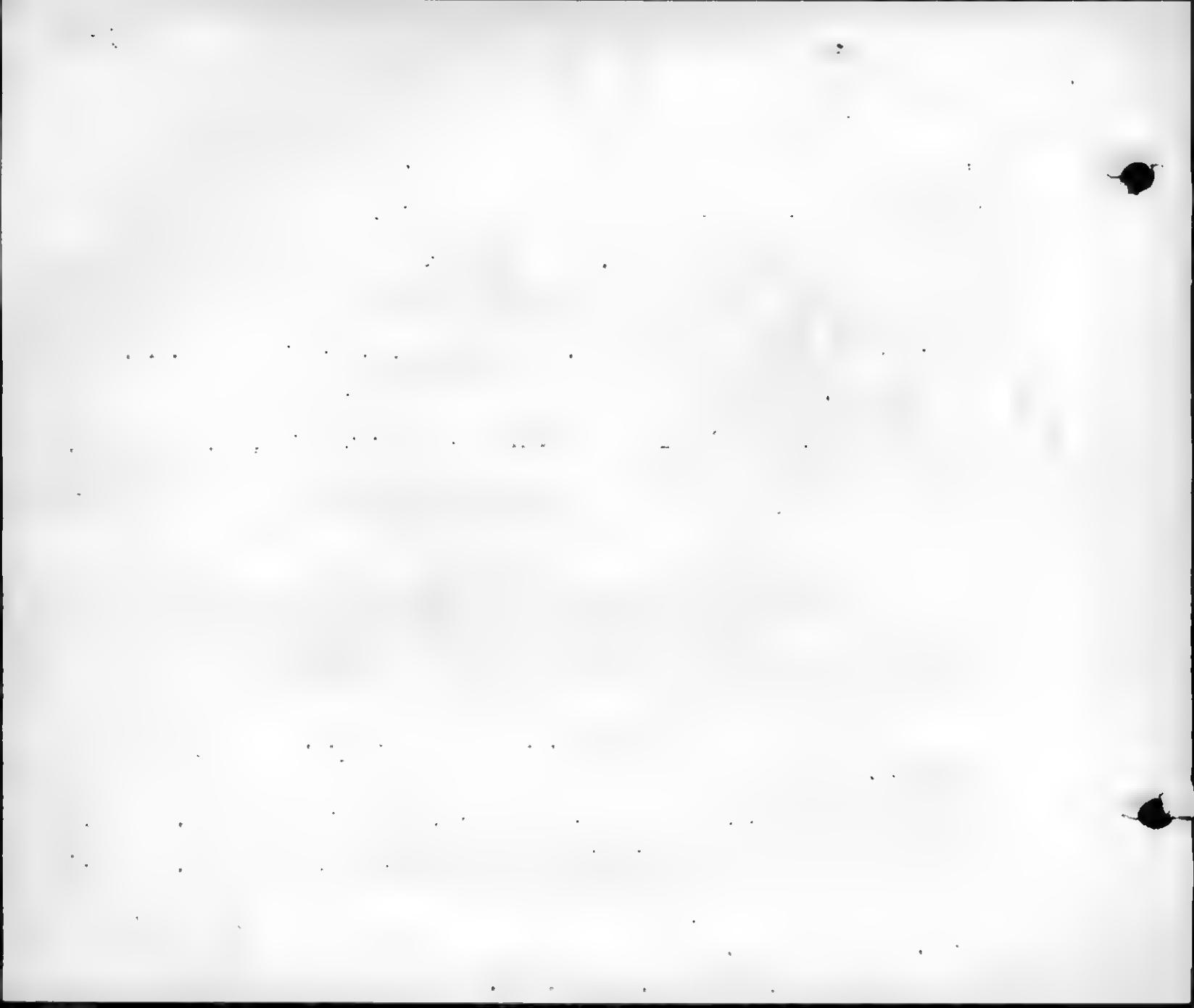
08853

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard | | c. LENGTH OF STAY IN 1b 40 minutes | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | First HENRY | Middle A. | Last SCHAFFER |
| 4. DATE OF DEATH August | Month 1959 | Day 19 | Year |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH March 19, 1908 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver Helper | | 10b. KIND OF BUSINESS OR INDUSTRY Furniture Co. | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland |
| 13. FATHER'S NAME Jacob J. Schaefer | | 14. MOTHER'S MAIDEN NAME Carrie Nicholas | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or date of service) Yes WW II | | 16. SOCIAL SECURITY NO. Yes --- | INFORMANT Clin. Records, VA Hospital, Ft. Howard, Md. |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH Unknown Unknown | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b) | |
| 20c. TIME OF INJURY Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that V.A. attended the deceased from August 9, 1959 to August 9, 1959 , and that death occurred at 1:20 A.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>Carroll E. Grindley</i> | | ADDRESS (Street, city or town, state) VA Hospital, Ft. Howard, Md. | |
| PHYSICIAN'S NAME (Type) | | DATE SIGNED 8/9/59 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 8/13/59 | |
| 22c. NAME OF CEMETERY OR CREMATORIAL Oaklawn Cemetery | | 22d. LOCATION (City, town, or county) Baltimore, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE John A. Moran - 3000 E. Baltimore Street | | 24a. ADDRESS John A. Moran - 3000 E. Baltimore Street | 24b. REC'D BY REGISTRAR DATA AUG 12 '59 |
| | | 24b. REGISTRAR'S SIGNATURE Carroll S. Kline | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death: Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8884 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 Items 3, 10, 11, 12, 13, 14, 16 FILE 8-21-59

08854

1 CERTIFICATE OF DEATH

Reg. Dist. No.

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|--|---------------------------|---|---|
| 1. PLACE OF DEATH o COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) o. STATE Maryland b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | c. LENGTH OF STAY IN b 2 months 10 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 28-1-4 | |
| d. STREET ADDRESS 4404 Eldiron Avenue | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) William | | First -Middle Schapiro | 4. DATE OF DEATH 8 - 26 - 1959 |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1895 Sept. 1, 1897 |
| 9. AGE (In years lost birthday) 136 yrs | | 10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0 | 11. IF UNDER 24 HRS Months 0 Days 0 Hours 0 Min 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown Salesman | | 10b. KIND OF BUSINESS OR INDUSTRY Furniture | 12. CITIZEN OF WHAT COUNTRY Bel Air, Md. U.S.A. |
| 13. FATHER'S NAME Unknown Jacob Schapiro | | 14. MOTHER'S MAIDEN NAME Bertha ? | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Unknown | | 16. SOCIAL SECURITY NO. 220-05-3168 | 17. INFORMANT Records, SPRING GROVE STATE HOSPITAL |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH Bronchial Pneumonia General Debility General Vascular Arteriosclerosis | |
| Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from Aug. 5, 1959, to Aug. 26, 1959, that I last saw the deceased alive on Aug. 26, 1959, and that death occurred at 10:45 A.M. from the causes and on the date stated above ACTUAL SIGNATURE P. K. Yip M.D. | | ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland DATE SIGNED | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 8-28-59 | | 22b. DATE THEREOF 8-28-59 | 22c. NAME OF CEMETERY OR CREMATORIAL Baltimore Hebrew |
| 23. FUNERAL DIRECTOR'S SIGNATURE Jack Lewinske | | 23. ADDRESS 2100 Gellaw Place | 24a. REC'D BY REGISTRAR DATE AUG 27 '59 |
| | | | 24b. REGISTRAR'S SIGNATURE C. L. & K. K. |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8885

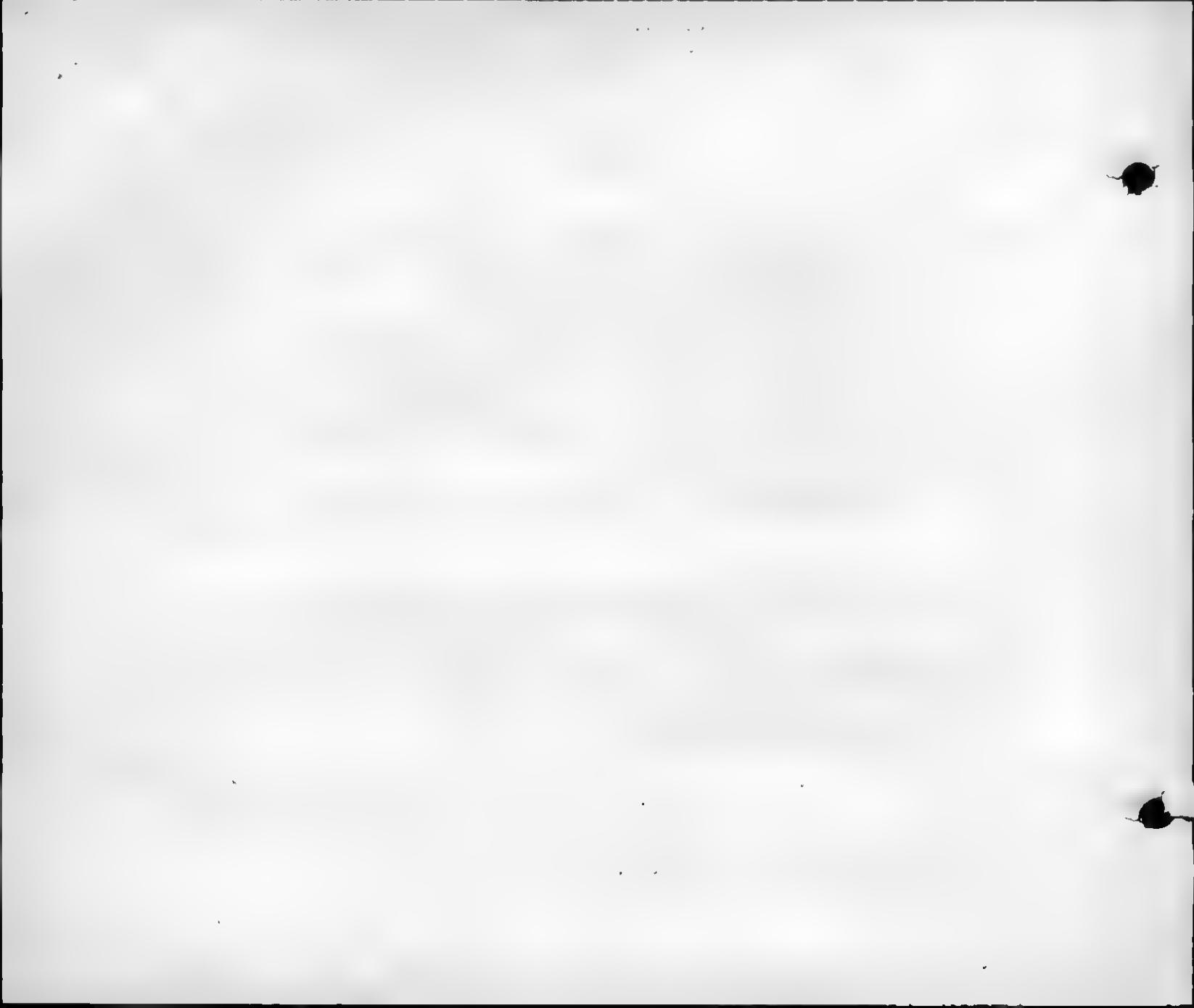
CERTIFICATE OF DEATH

08855

Reg. Dist. No.

HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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| PLACE OF DEATH a. COUNTY Baltimore | | MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) a. STATE Maryland | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | c. LENGTH OF STAY IN 1b 1 year 1 month, 1 day | | b. COUNTY TOWSON | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Grove State Hospital | | d. STREET ADDRESS Dulaney Valley Road | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Mary | Middle Teresa | Last Schell | 4. DATE OF DEATH August 2 1959 | Month Aug | Day 2 Year 1959 |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 2-12-74 | 9. AGE (In years at birthday) 85 | 10. IF UNDER 1 YEAR Months Days |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown HOUSEWORK | | 10b. KIND OF BUSINESS OR INDUSTRY Unknown AT HOME | | 11. BIRTHPLACE (State or foreign country) BALTIMORE UNKNOWN MD. | |
| 13. FATHER'S NAME Unknown JACOB SCHELL | | 14. MOTHER'S MAIDEN NAME Unknown MARCARET MOHR. | | 12. CITIZEN OF WHAT COUNTRY Unknown U.S.A. | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown | | 16. SOCIAL SECURITY NO. Unknown | | 17. INFORMANT Spring Grove State Hospital Record Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1. DUE TO Arteriosclerotic cardiovascular disease INTERVAL BETWEEN ONSET AND DEATH Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Generalized arteriosclerosis (c) | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | |
| 20c. TIME OF INJURY Month, Doy, Year Hour a. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from June 12, 1958, to August 2nd, 1959, that I last saw the deceased alive on August 2nd, 1959, and that death occurred at 5:00 P.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Stella Wachsler M.D. SPRING GROVE STATE HOSPITAL 8-3-59 | | | | | |
| PHYSICIAN'S NAME (Type) Stella Wachsler, M. D. | | Catonsville 28, Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 8/6/59 | | 22c. NAME OF CEMETERY OR CREMATORIAL HOLY REDEEMER | |
| 22d. LOCATION (City, town, or county) (State) BECNR RD MD | | 24a. REC'D BY REGISTRAR DATE AUG 5 '59 | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Sylvia Ross | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | | | |



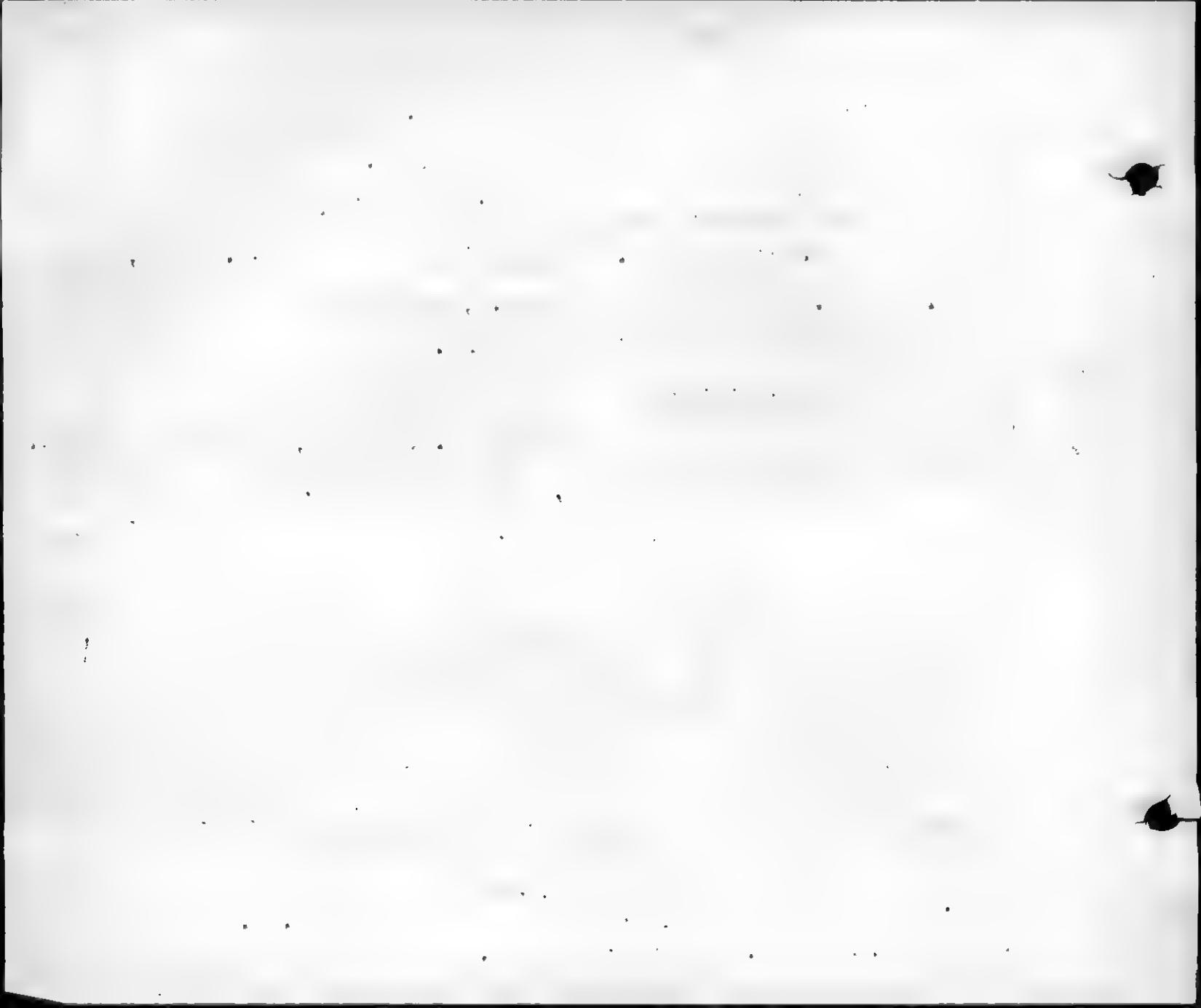
TO HOSPITAL OR ATTENDING PHYSICIAN: Fill in that the death certificate is executed within 24 hours of death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 8886 CERTIFICATE OF DEATH

Reg. Dist. No. 08856

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|---|--|--|-------------------------|--|--|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived—If institution, Residence before admission) a. STATE Md. b. COUNTY | | | | | | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Balto. | | | | | | | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ridgeway Manor 5743 Edmondson Ave. | | d. STREET ADDRESS 3212 Strickland St | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) Charles | | First H. | Middle Schlining | | | | | | | | | | |
| Last Aug. | | Month 21, | Day 1959 | | | | | | | | | | |
| 4. DATE OF DEATH | | 5. SEX M. | | 6. COLOR OR RACE W. | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Dec. 3, 1885 | | 9. AGE (In years last birthday) 73 yrs. | | 10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. Months 73 Days 0 Hours 0 Min. 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sign Painter | | 10b. KIND OF BUSINESS OR INDUSTRY B&O Railroad | | 11. BIRTHPLACE (State or foreign country) Md. | | 12. CITIZEN OF WHAT COUNTRY? USA | | | | | | | |
| 13. FATHER'S NAME Louis Schlining | | 14. MOTHER'S MAIDEN NAME Unknown | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. INFORMANT | | 17. ADDRESS Charles K. Schlining, 3205 Strickland St. | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Heart Disease</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>Buerger's disease</i> DUE TO (c) | | 19. INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> <i>8 years</i> | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 20. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | |
| 20c. TIME OF INJURY Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) Balto. | | (County) Md. | | (State) Md. | | | |
| 21. I certify that I attended the deceased from 1951 , 19, to Aug 21 , 1959, that I last saw the deceased alive on Aug 21 , 1959, and that death occurred at 11:50 A.M. from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) Baltimore, Md. | | DATE SIGNED Aug 26 '59 | | | | | | | | | |
| ACTUAL SIGNATURE <i>James J. Plogher, 3205 Strickland St.</i> | | PHYSICIAN'S NAME (Type) | | | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 8/25/59 | | 22c. NAME OF CEMETERY OR CREMATORIUM Loudon Park | | 22d. LOCATION (City, town, or county) Balto. Md. | | (State) Md. | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Witzke Funeral Dir. 4101 Edmondson Ave. | | ADDRESS 4101 Edmondson Ave. | | 24a. REC'D BY REGISTRAR DATE AUG 26 '59 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kline | | | | | | | |



X

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8887 CERTIFICATE OF DEATH

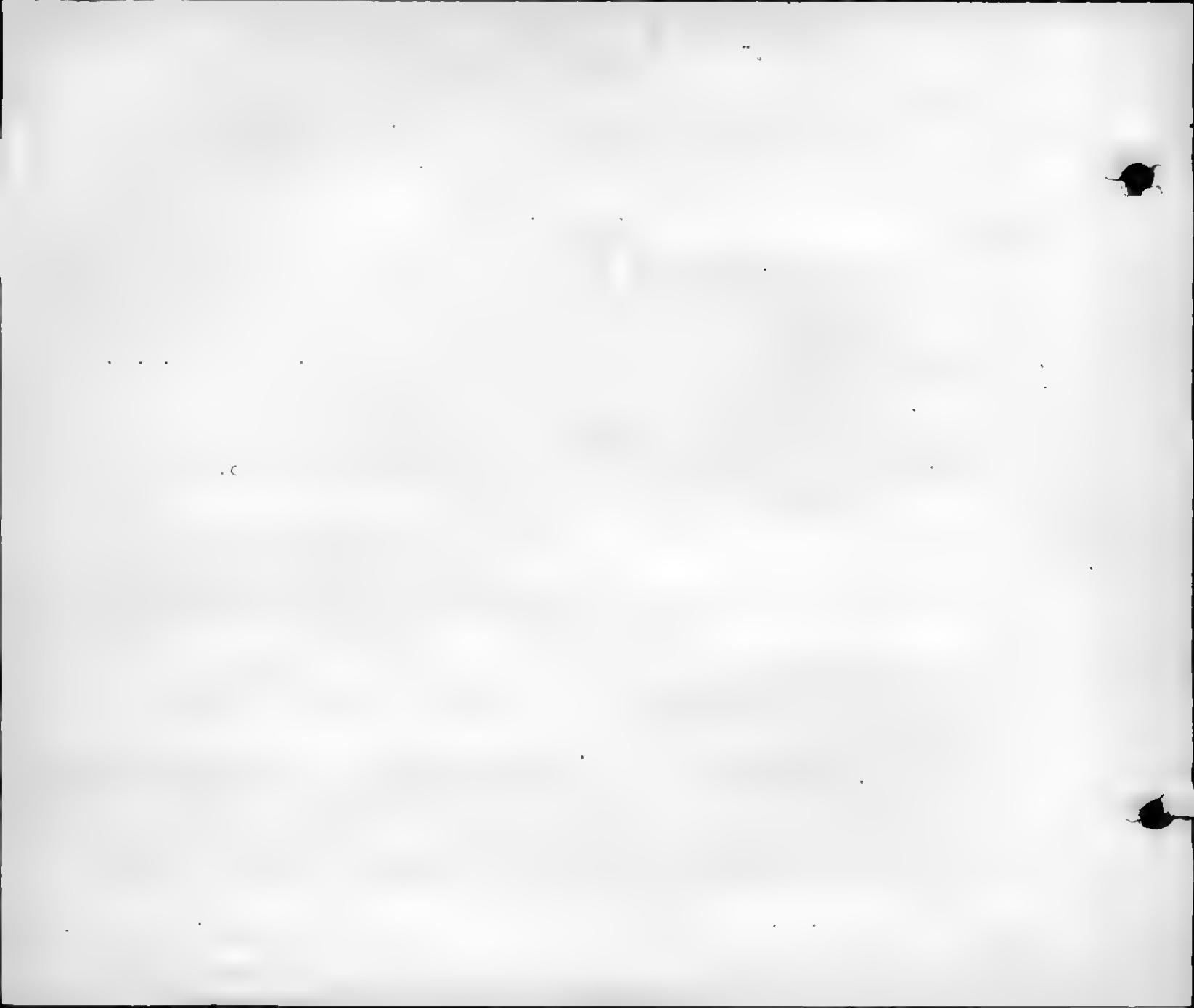
Reg. Dist. No. 08857

TO HOSPITAL OR ENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death: Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | | |
|---|--|--|---|---|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. | | b. COUNTY Baltimore | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson | | c. LENGTH OF STAY IN 1b RURAL and give nearest town) | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockdale Maryland | | d. STREET ADDRESS 8329 Merrymount Drive | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Armacost Nursing Home Regester Ave. | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print) FRANK B. SCHNAPP | | First | Middle | Last | 4. DATE OF DEATH | Month | Day | Year |
| 5. SEX Male | | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | B. DATE OF BIRTH May 4, 1889 | 9. AGE (In years last birthday) 70 | 10. IF UNDER 1 YEAR Months 0 | 11. IF UNDER 24 HRS Days 0 | 12. IF UNDER 24 HRS Hours 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Wilkes Barre Pa. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME J. Bernard Schnapp | | | | 14. MOTHER'S MAIDEN NAME Charolette Nellius | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 212-10-9220 | | 17. INFORMANT Elizabeth Magdalene Schnapp | | Address | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) | | DUE TO 180X | | 8329 Merrymount Drive Balto. 7, | | INTERVAL BETWEEN ONSET AND DEATH 2 min | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. { | | (b) DUE TO Diffuse hepatic metastases with ascites | | | | 1 month | | |
| | | (c) DUE TO Renal cell carcinoma with metastases | | | | 5 months | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m p. m. | | 20d. INJURY OCCURRED White at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) Shavertown, Pa. | | (County) Shavertown (State) Pa. |
| 21. I certify that I attended the deceased from alive on Aug. 8, 1959 , and that death occurred at 7:11P.M. from the causes and on the date stated above. | | | | | | ADDRESS (Street, city or town, state) 1008 Regester Avenue | | DATE SIGNED 8/9/59 |
| ACTUAL SIGNATURE <i>Dirk Van Peenen</i> | | M.D. | | | | | | |
| PHYSICIAN'S NAME (Type) Dirk Van Peenen | | | | | | | | |
| 22a. BURIAL, CREMATION REMOVAL (Specify) Burial | | 22b. DATE THEREOF Aug. 13, 1959 | | 22c. NAME OF CEMETERY OR CREMATORIUM Saint Nicholas Cemetery | | 22d. LOCATION (City, town, or county) Shavertown, Pa. | | (State) |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Armacost</i> | | ADDRESS ELLISWORTH AR MACOST 4600 Liberty Heights | | 24a. REC'D BY REGISTRAR Aug 11 '59 | | 24b. REGISTRAR'S SIGNATURE <i>Charles S. Kraus</i> | | |



TO HOSPITAL OR
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director.
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

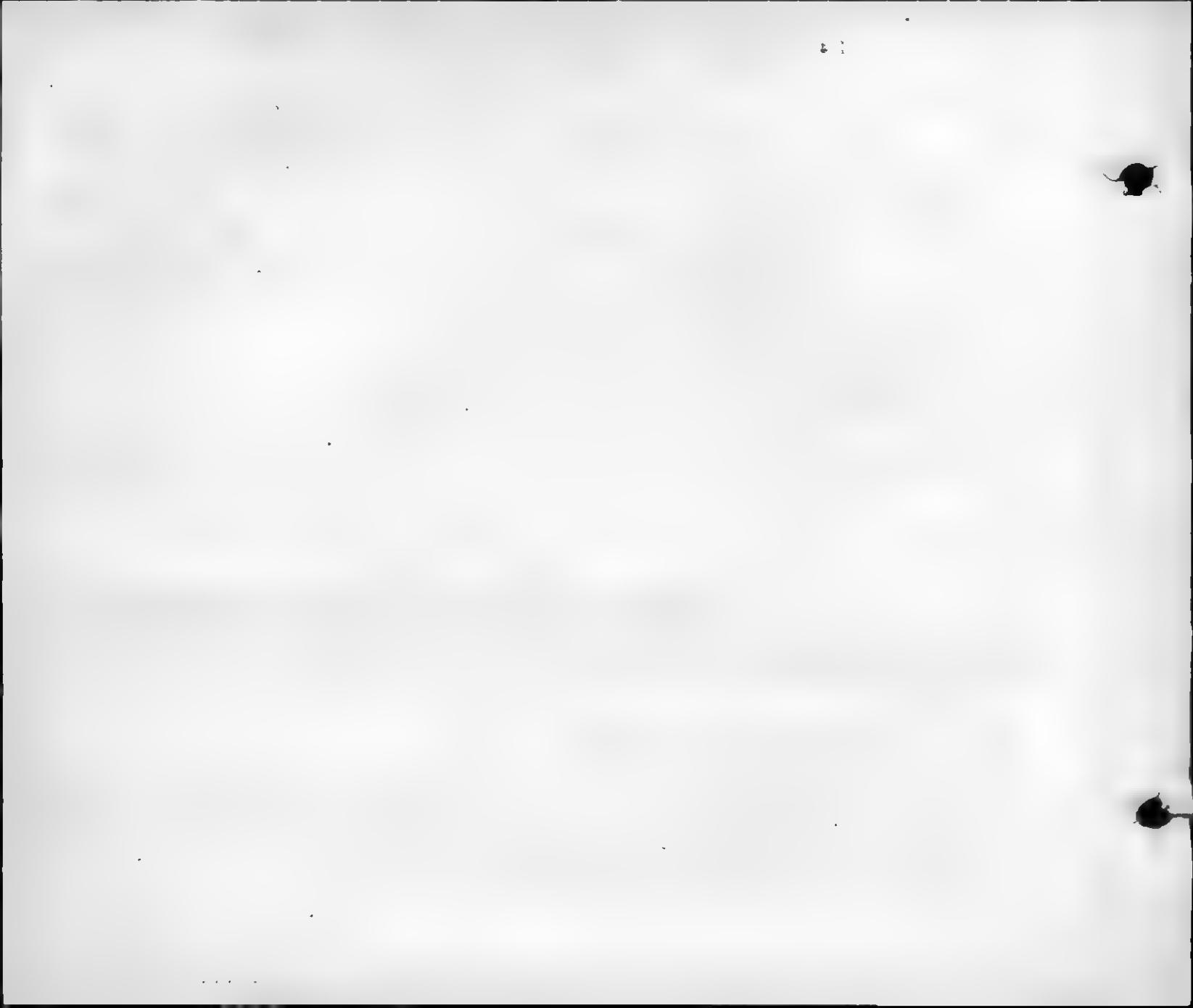
08858

8888

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | | | |
|--|---------------------------|--|--|--|---|--|---------------------|----------|------------------------|
| 1. PLACE OF DEATH a. COUNTY Balto Co Md | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE 2808 Louisiana Ave English Consul Balto | | b. COUNTY Balto | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltosville | | c. LENGTH OF STAY IN 1b 5 wks | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Balto Highlands Balto Co Md | | d. STREET ADDRESS | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ridgeway Nursing Home | | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) Florence E Schwartz | | First | Middle | Lost | 4. DATE OF DEATH Aug. 16-1959 | Month | Day | Year | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH March 1878 ? 81 yrs | 9. AGE (In years lost birthday) | IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Baltimore Co Md | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME William Wade | | 14. MOTHER'S MAIDEN NAME Susian Kessler | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Frank J Schwartz 2808 Louisiana Ave Balto Co Md | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH 2 mo. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of rectum. | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Cancer of rectum. | | | | | | | |
| 20c. TIME OF INJURY Hour a. m. p. m. | | Month 19 | Day | Year | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) |
| 21. I certify that I attended the deceased from _____, 1957, to _____, 1957, that I last saw the deceased alive on _____, 1957, and that death occurred at _____, from the causes and on the date stated above. ACTUAL SIGNATURE J. William Pickay M.D. | | | | | | ADDRESS (Street, city or town, state) 6014 Edmondson Ave. (28) | | | DATE SIGNED 8-17-59 |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 8-19-59 | | 22c. NAME OF CEMETERY OR CREMATORIAL Meadow Ridge Cem | | 22d. LOCATION (City, town, or county) Washington Blvd Elkridge Md | | (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Edna rd Toulson | | ADDRESS 2359 Wash Blvd Balto 30 Md | | 24a. REC'D BY REGISTRAR DATE AUG 24 '59 | | 24b. REGISTRAR'S SIGNATURE Cynthia K. Kline | | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

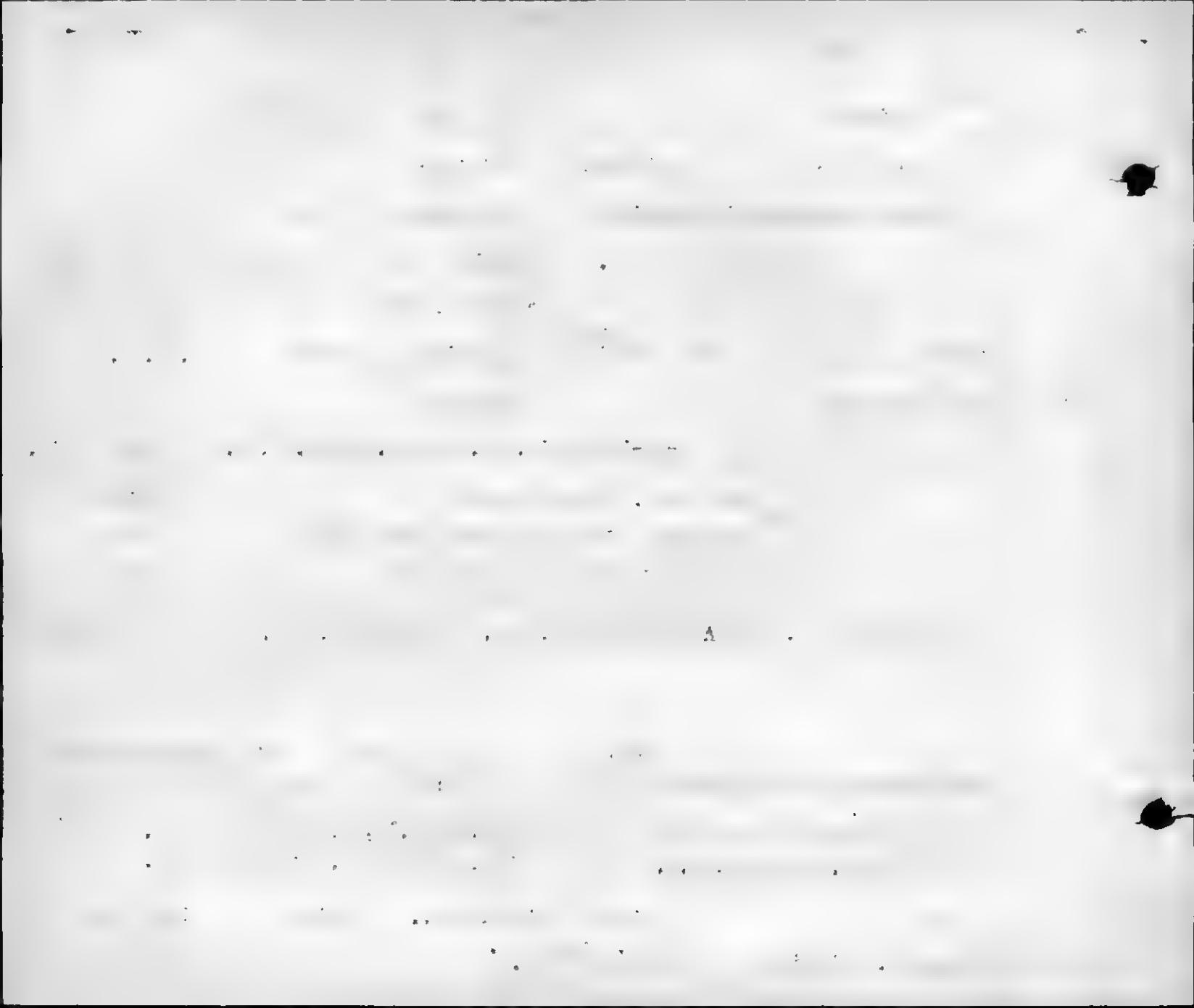
8889

CERTIFICATE OF DEATH

08859

Reg. Dist. No.

| | | | | | | | |
|---|------------------------------------|--|--|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland | | b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard | | c. LENGTH OF STAY IN lb 171 Days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | | (17) | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital | | d. STREET ADDRESS 616 Reservoir Street | | e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) | First VERNON | Middle E. | Last SEABORNE | 4. DATE OF DEATH August | Month 31 | Day 1959 | Year |
| S. SEX Male | 6. COLOR OR RACE Colored | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH October 7, 1907 | 9. AGE (in years last birthday) 51 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Presser | | 10b. KIND OF BUSINESS OR INDUSTRY Plant Dry Cleaning / | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Samuel Seaborn | | | | 14. MOTHER'S MAIDEN NAME Sara Reed | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or Unknown) Yes | | 16. SOCIAL SECURITY NO 216-01-3981 | | 17. INFORMANT Clin. Rec. VA Hosp., Balto. 18, Md. Fort Howard Div. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA, FLOOR OF MOUTH INTERVAL BETWEEN ONSET AND DEATH UNKNOWN 143X XX Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) FULMINARY INFARCTION, RIGHT LOWER LOBE RECENT XX (c) FULMINARY CONGESTION AND EDEMA RECENT | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) ARTERIOSCLEROSIS, MODERATELY ADVANCED, OLD. EMACIATION, OLD. | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) VA | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) ADDRESS (Street, city or town, state) VAH, BALTO. 18, MD, FORT HOWARD DIV. | (County) DATE SIGNED 9/1/59 |
| 21. I certify that I attended the deceased from March 13, 1959 to August 31, 1959 , and that death occurred at 8:05 P.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <i>John W. Crawford</i> | | ADDRESS (Street, city or town, state) VAH, BALTO. 18, MD, FORT HOWARD DIV. | | | | | |
| PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, M.D. | | DATE SIGNED 9/1/59 | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 9/4/59 | | 22c. NAME OF CEMETERY OR CREMATORIAL Baltimore National Cem. | | 22d. LOCATION (City, town, or county) Baltimore (State) Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Arlington S. Phillips | | 1805 N. Monroe St. Baltimore 17, Md. | | 24a. REC'D BY REGISTRAR DATE SEP 8 '59 | | 24b. REGISTRAR'S SIGNATURE Arthur L. Evans | |



TO DEPUTY M. E. EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained by your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

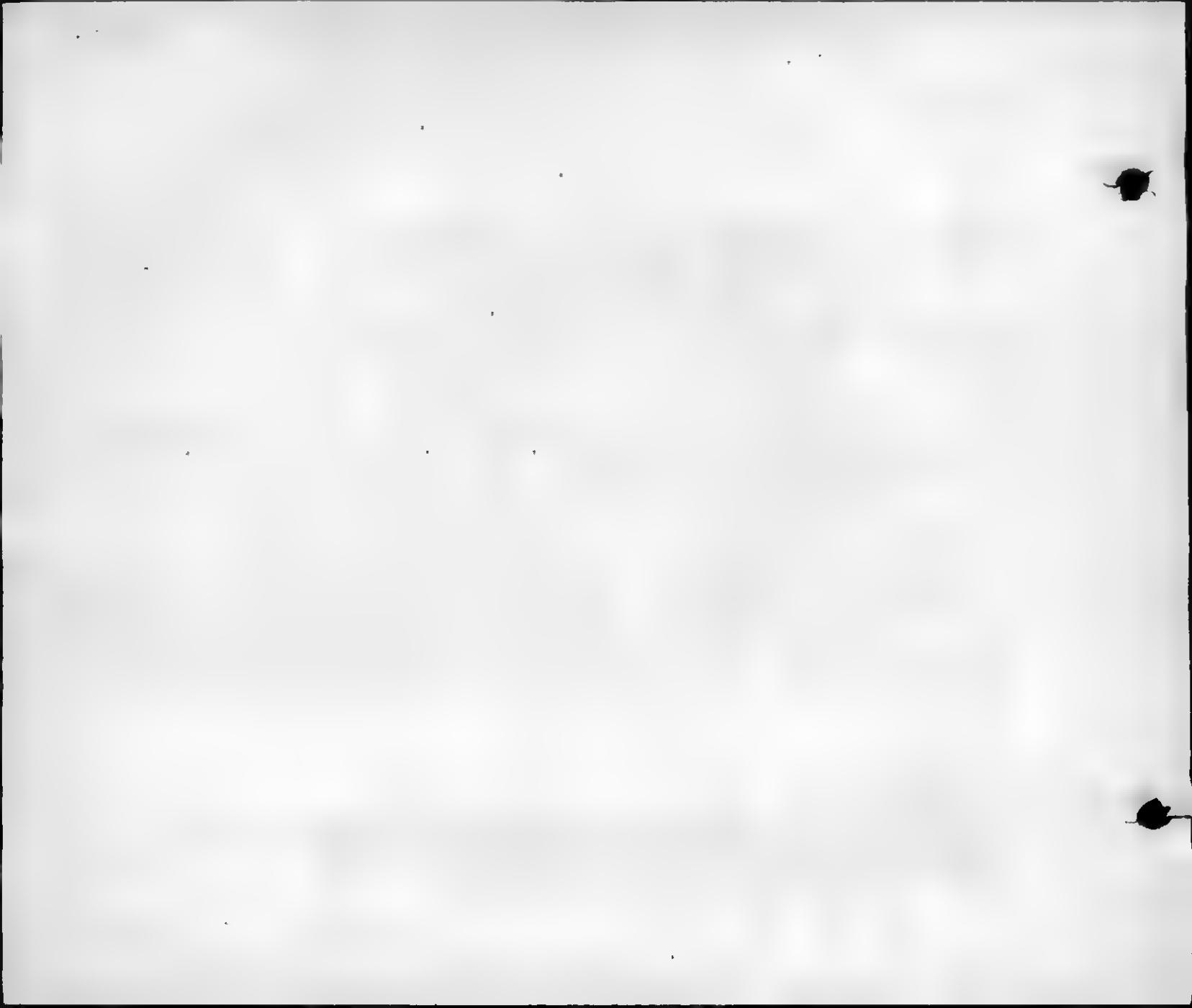
1 X
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8890 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08860

Reg. Dist. No.

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore | MARYLAND | 2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) b. STATE Md. | b. COUNTY Baltimore |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Lutherville | c. LENGTH OF STAY IN 1b 20 Yrs. | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) d. STREET ADDRESS Ridgeway Ave. | d. STREET ADDRESS |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | e. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) James William Seal | First | Middle | Last |
| 4. DATE OF DEATH AUGUST 19, 1959 | Month | Day | Year |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH Jan. 15, 1875 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | 10b. KIND OF BUSINESS OR INDUSTRY Herb Shirley | 11. BIRTHPLACE (State or foreign country) Virginia | 9. AGE (In years last birthday) 81 yrs |
| 13. FATHER'S NAME William Seal | 14. MOTHER'S MAIDEN NAME Fannie Seal | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or Unknown) No | 16. SOCIAL SECURITY NO 217-125996 |
| 17. INFORMANT Mr. Marvin Seal, Ridgeway Ave., Lutherville | | Address Maryland | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO ARTERIOSCLEROTIC C.V. DISEASE (c) | | 19. INTERVAL BETWEEN ONSET AND DEATH 30 MIN. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) | | |
| 20c. TIME OF INJURY Hour p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE MARTIN E. STROBEL | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | DATE SIGNED 8/20/59 | |
| EXAMINER'S NAME (Type) MARTIN E. STROBEL | for DDCAPLES | | |
| 22a. BURIAL CREMATION REMOVAL (Specify) 11:24 a.m. | 22b. DATE THEREOF Aug. 22, 1959 | 22c. NAME OF CEMETERY OR CREMATORIAL Lorraine Park Cemetery | 22d. LOCATION (City, town, or county) Baltimore, Maryland |
| 23. FUNERAL DIRECTOR'S SIGNATURE Frank J. Neely, William Seal | ADDRESS | 24a. REC'D BY REGISTRAR AUG 24 '59 | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus |



may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8891 CERTIFICATE OF DEATH

08861

Reg. Dist. No.

| | | | |
|--|--------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore | | 2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL | | c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2917 Topaz Road | | d. STREET ADDRESS 2917 Topaz Road #14 | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) MARGARET | | First J. | Middle SHEPPARD |
| 4. DATE OF DEATH August 11 | Month 19 | Day 59 | Year |
| 5. SEX Female | | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 8. DATE OF BIRTH July 3, 1896 | | 9. AGE (in years last birthday) 63 yrs | 10. IF UNDER 1 YEAR IF UNDER 24 HRS Months 0 |
| 10a. US/JAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Person | | 10b. KIND OF BUSINESS OR INDUSTRY Martha Washington Ice Cream Stores | 11. BIRTHPLACE (State or foreign country) Balto. Md. |
| 13. FATHER'S NAME Howard Wright | | 14. MOTHER'S MAIDEN NAME Laura Yost | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) No | | 16. SOCIAL SECURITY NO 220-22-6023 | 17. INFORMANT Mr. Elmer W. Sheppard-2917 Topaz Road #14 |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260X | | INTERVAL BETWEEN ONSET AND DEATH General Hemorrhage | |
| Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO Hypertension & V. Disease | | 1 1/2 yrs | |
| DUE TO Diabetic Mellitus | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. Aug. 11, 1959 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 7101 Harford Rd. |
| 20f. (City or town) Baltimore | | (County) M.D. | |
| | | (State) Maryland | |
| 21. I certify that I attended the deceased from Jan. , 1949 to Aug. 11, 1959 , that I last saw the deceased alive on Aug. 11, 1959 , and that death occurred at 1150 P.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>Milton Janney</i> | | ADDRESS (Street, city or town, state) 7101 Harford Rd. | |
| PHYSICIAN'S NAME (Type) M. J. Janney | | DATE SIGNED 8/12/59 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 8/14/59 | 22c. NAME OF CEMETERY OR CREMATORIAL Balto. National Cemetery |
| 22d. LOCATION (City, town, or county) Baltimore, Maryland | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>M. J. Janney</i> | | 24a. REC'D BY REGISTRAR AUG 12 '59 | 24b. REGISTRAR'S SIGNATURE <i>Albert S. Krause</i> |



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

8892 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

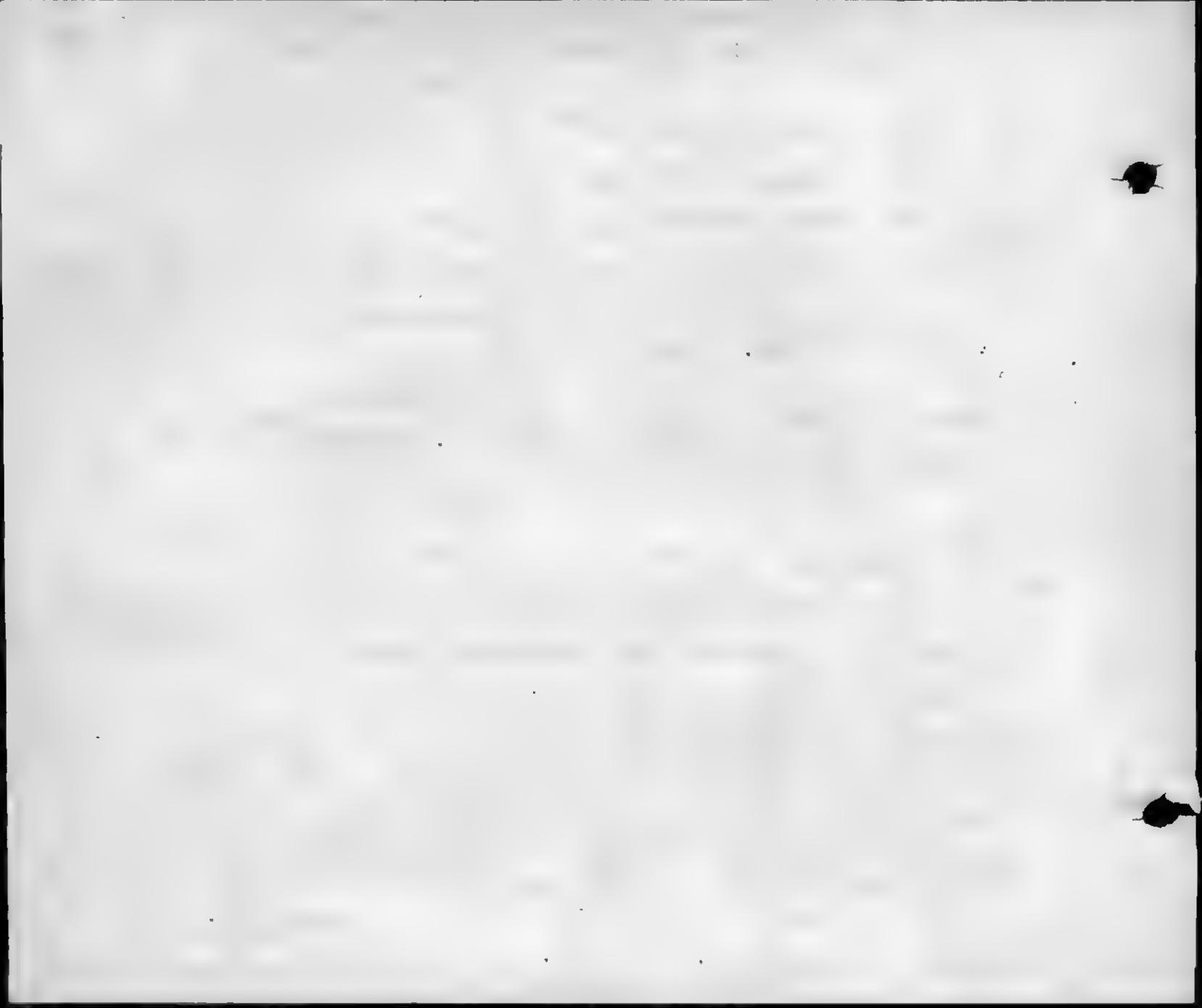
08862

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial or cremation, or removal.

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY BALTIMORE | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MD b. COUNTY BALTIMORE | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PHOENIX | | c. LENGTH OF STAY IN 1b life | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) COOPER RD | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PHOENIX | |
| 3. NAME OF DECEASED (Type or print) JOHN | | First JOHN | Middle CARROLL |
| 3. NAME OF DECEASED (Type or print) JOHN | | 3. NAME OF DECEASED (Type or print) JOHN | 3. NAME OF DECEASED (Type or print) JOHN |
| 4. DATE OF DEATH Aug. 6 1959 | | Month Aug. | Day 6 |
| 5. SEX M | | 6. COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 8. DATE OF BIRTH 7-23-00 | | 9. AGE (In years last birthday) 59 yr. | 10. IF UNDER 1 YEAR, IF UNDER 24 HRS. Months 5 Days 0 Hours 0 Min. 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER mang. | | 10b. KIND OF BUSINESS OR INDUSTRY farm dairy | 11. BIRTHPLACE (State or foreign country) MD. |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME WILMER D. SHEPPERD | |
| 14. MOTHER'S MAIDEN NAME Alice Watson | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) No | |
| 16. SOCIAL SECURITY NO. none | | 17. INFORMANT Eleanor P. Shepperd, Above | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS | | INTERVAL BETWEEN ONSET AND DEATH 5 MIN. | |
| 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO | | | |
| 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour a. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE William A. Pillsbury | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) William A. Pillsbury | | DATE SIGNED 8/6/59 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 8-9-59 | |
| 22c. NAME OF CEMETERY OR CREMATORIAL Clynnmalian Methodist | | 22d. LOCATION (City, town, or county) Phoenix, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Brooks Funeral Service, Towson, Md. | | 24e. REC'D BY REGISTRAR Arthur S. Trahan | |
| ADDRESS Brooks Funeral Service, Towson, Md. | | 24f. REGISTRAR'S SIGNATURE Arthur S. Trahan | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

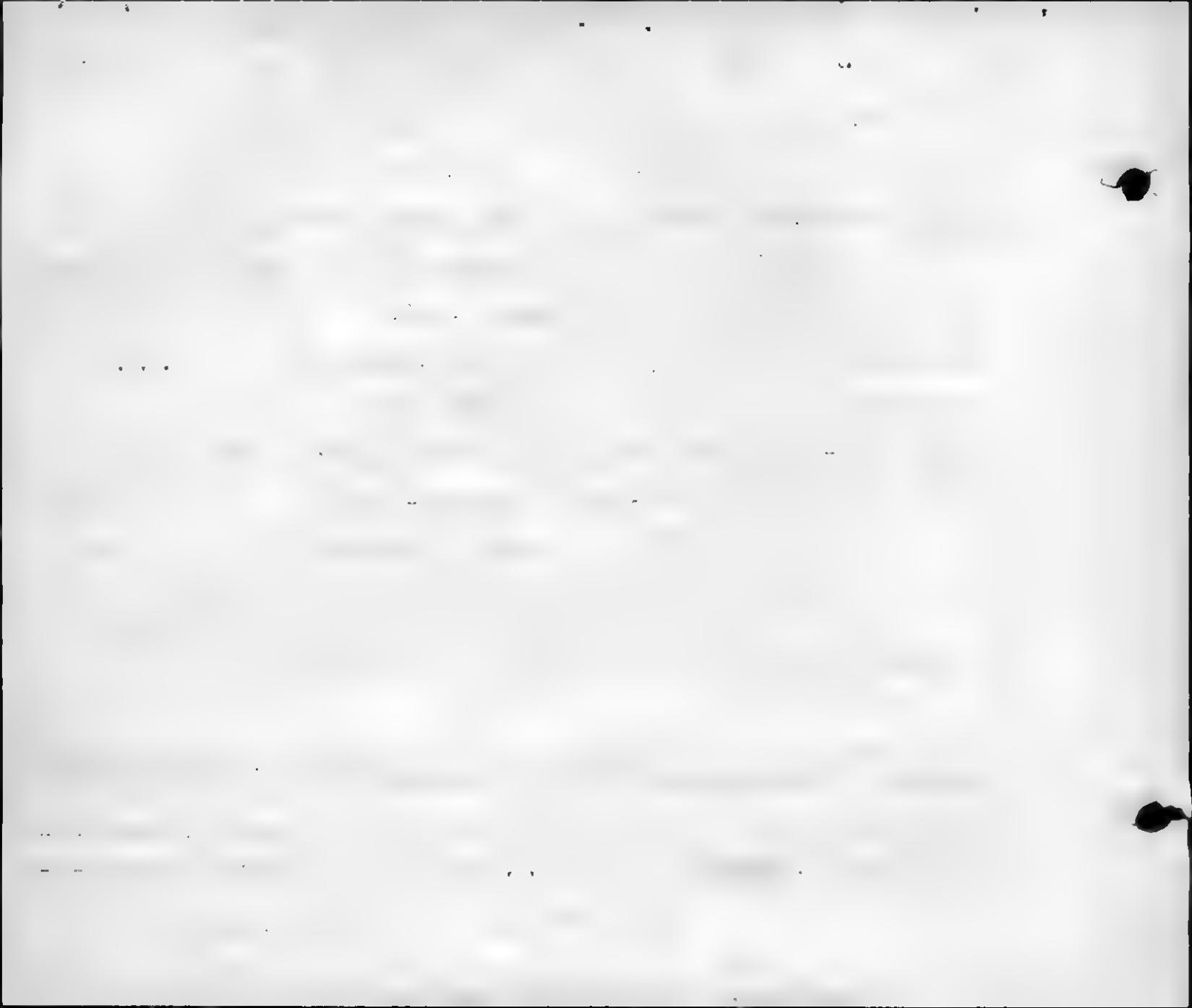
8893

CERTIFICATE OF DEATH

Reg. Dist. No.

08863

| | | | | | | | | |
|---|----------------------------------|---|--|--|---|--|------------------|----------------------|
| 1. PLACE OF DEATH a. COUNTY BALTIMORE | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND | | b. COUNTY | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD | | c. LENGTH OF STAY IN 1b 121 DAYS | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE | | d. STREET ADDRESS 1077 ELLICOTT DRIVE | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL | | | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print) JOHN | | First F | Middle SHOWELL | Lost | 4. DATE OF DEATH AUGUST 21 1959 | Month AUGUST | Day 21 | Year 19 59 |
| 5. SEX MALE | 6. COLOR OR RACE NEGRO | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH April 1, 1912 | | 9. AGE (In years from birthday) 47 yrs. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRUCK DRIVER | | 10b. KIND OF BUSINESS OR INDUSTRY City of Baltimore Sanitation Dept | | 11. BIRTHPLACE (State or foreign country) DENTON, MARYLAND | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | | |
| 13. FATHER'S NAME JOHN SHOWELL | | 14. MOTHER'S MAIDEN NAME EDITH TURPIN | | | | Address | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES | | 16. SOCIAL SECURITY NO. WW-11-219-01-7018 | | 17. INFORMANT CLIN REC VAH BALTO MD-FT HOWARD DIVISION | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PERIPHERO-VASCULAR COLLAPSE - SHOCK DUE TO <i>1-17-12</i> | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> <u>lying cause lost.</u> | | (b) CARCINOMATOSIS (ANAPLASTIC CARCINOMA) DUE TO <i>1-17-12</i> | | | | INTERVAL BETWEEN ONSET AND DEATH 4 HOURS | | |
| (c) | | | | | | UNKNOWN | | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.) | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that I attended the deceased from April 22, 1959 to August 21, 1959 , and that death occurred at 10:55 p.m. from the causes and on the date stated above ACTUAL SIGNATURE: <i>Samuel J. Mangus</i> M.D. VAH | | | | | | ADDRESS (Street, city or town, state) DATE SIGNED Ft. Howard Maryland 8-22-59 | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 8/25/59 | | 22c. NAME OF CEMETERY OR CEMETORY Baltimore National | | 22d. LOCATION (City, town, or county) (State) Baltimore, Maryland | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Geo. S. Kelson</i> | | ADDRESS 1348 N. Calhoun St. | | 24a. REC'D BY REGISTRAR DATE Aug 27 '59 | | 24b. REGISTRAR'S SIGNATURE <i>George S. Kelson</i> | | |



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MS AT5ME
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8761 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08864

Reg. Dist. No.

| | | | | | | | |
|--|--|---|--|---|---|---|-----------------------------------|
| 1. PLACE OF DEATH a. COUNTY Baltimore | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland | | b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk (22) | | c. LENGTH OF STAY IN 1b 5 Years | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Dundalk (22) | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2903 Dunmore Road | | d. STREET ADDRESS 2903 Dunmore Road | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) ESTELLE BELLE SIGMOND | | First | Middle | 4. DATE OF DEATH August 3rd, 1959 | Month | Doy | Year |
| 5. SEX female | | 6. COLOR OR RACE white | 7. MARRIED WIDOWED <input type="checkbox"/> | 8. DATE OF BIRTH Nov. 22, 1897 | 9. AGE (In years at birthday) 61 yrs. | 10. IF UNDER 1 YEAR Months Days | 11. IF UNDER 24 HRS Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Germany | | 12. CITIZEN OF WHAT COUNTRY? Germany | |
| 13. FATHER'S NAME Felix Shorff | | 14. MOTHER'S MAIDEN NAME Mary ??? | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO none | | 17. INFORMANT John Sigmond | | Address same as #2 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 42 ii DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | 19. INTERVAL BETWEEN ONSET AND DEATH 51 hours | | 20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 21. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. TIME OF INJURY Hour a. m. p. m. 19 | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20d. (City or town) (County) (State) | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | 22. ACTUAL SIGNATURE Jack C. Collins, M.D. | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED 8/3/59 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 8/9/59 | | 22c. NAME OF CEMETERY OR CREMATORIUM St. Raymonds Cemetery | | 22d. LOCATION (City, town, or county) Bronx, New York, New York (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Walter Brooks Bradley Inc. | | ADDRESS Dundalk 22, Md. | | 24a. REC'D BY REGISTRAR DATE AUG 5 '59 | | 24b. REGISTRAR'S SIGNATURE Arthur L. Thomas | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08865

Reg. Dist. No.

8894

TO DIRECTOR OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or removal.

| | | | | | | | | | |
|---|----------------------------------|---|---------------------------------------|---|---|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KINGSVILLE - Md | | c. LENGTH OF STAY IN 1b LIFE | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland | | b. COUNTY Baltimore | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Bowles Farm, Jerusalem Road | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KINGSVILLE Md. | | d. STREET ADDRESS Bowles Farm, Jerusalem Road | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) | First ROBERT | Middle C. | Last SMALL | 4. DATE OF DEATH August 25, 1959 | Month August | Day 25 | Year 1959 | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH 10-24-1895 | 9. AGE (in years at birthday) 63 | 10. IF UNDER 1 YEAR Months 3 | Days 15 | 11. IF UNDER 24 HRS. Hours 0 | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER | | 10b. KIND OF BUSINESS OR INDUSTRY FARM | | 11. BIRTHPLACE (State or foreign country) BALTO. CO. MD. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME ALEC SMALL | | 14. MOTHER'S MAIDEN NAME SUSAN MOSSBERG | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT DAVID SMALL 15 GLADE AVE | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of lung | | DUE TO Conditions, if any, which give rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | | | INTERVAL BETWEEN ONSET AND DEATH PARTIAL | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) PARTIAL | |
| 20f. (City or town) None | | (County) None | | (State) None | | 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| ACTUAL SIGNATURE <i>William V. Lovitt</i> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED 8/25/59 | | | | | |
| EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D. | | 22b. DATE THEREOF 8-25-59 | | 22c. NAME OF CEMETERY OR CREMATORIAL MT. CHRISTIAN CEM. | | 22d. LOCATION (City, town, or county) NARFORD CO. MD. | | (State) | |
| 22e. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23. FUNERAL DIRECTOR'S SIGNATURE LaSalle Fun. Home 7401 Bkfst Rd. | | ADDRESS LaSalle Fun. Home 7401 Bkfst Rd. | | 24a. REC'D BY REGISTRAR DATE AUG 27 '59 | | 24b. REGISTRAR'S SIGNATURE Arthur & Anna | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

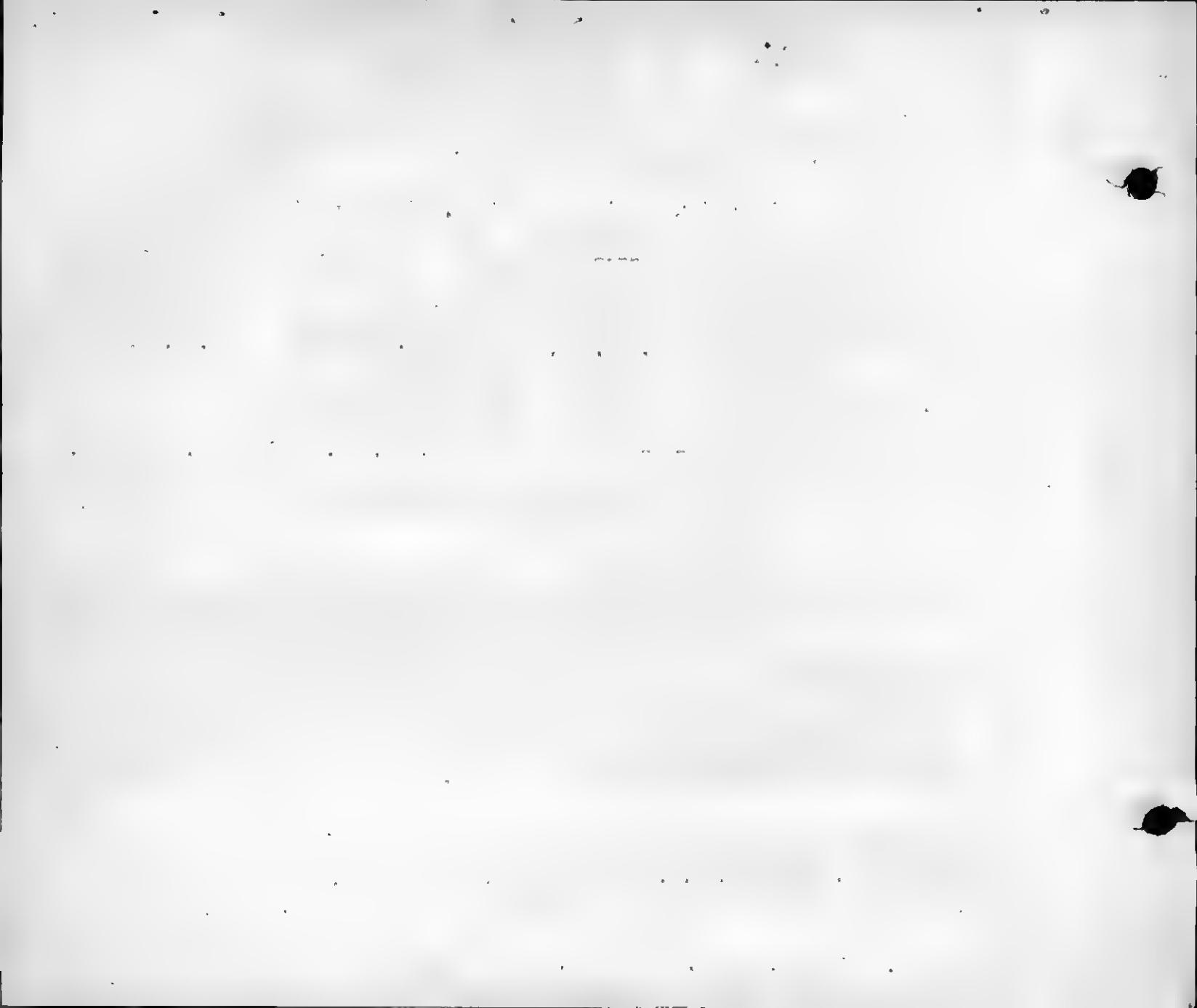
8895

CERTIFICATE OF DEATH

08866

Reg. Dist. No.

| | | | | | | | | | |
|--|--|---|---|---|----------------------------------|--|-------------------------------|-----------------------------|---------|
| 1. PLACE OF DEATH a. COUNTY Baltimore | | MARYLAND | | 2. USUAL RESIDENCE [Where deceased lived if institution Residence before admission] a. STATE Maryland | | b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard | | c. LENGTH OF STAY IN 1b 8 Days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital | | | | d. STREET ADDRESS 813 W. Edmondson Street | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) EARL | | First | Middle | Last | 4. DATE OF DEATH August | Month | Day | Year | |
| 5. SEX Male | | 6. COLOR OR RACE Colored | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH January 9, 1924 | | 9. AGE (In years from birthday) 35 | 10. IF UNDER 1 YEAR Months | 11. IF UNDER 24 HRS Days | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur | | 10b. KIND OF BUSINESS OR INDUSTRY US Govt. Soc. Sec. | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY U. S. A. | | | |
| 13. FATHER'S NAME John R. Smith | | | | 14. MOTHER'S MAIDEN NAME Beatrice Taylor | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO. WW II 216-16-9636 | | 17. INFORMANT Clin. Records, Vet. Adm. Hospital, Ft. Howard, Md. | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | MALIGNANT NEPHROSCLEROSIS WITH UREMIA DUE TO MALIGNANT HYPERTENSION | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) OR (c) | | UNKNOWN RECENT | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | INTERVAL BETWEEN ONSET AND DEATH 3 WEEKS | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) VA | | (County) | (State) |
| 21. I certify that I attended the deceased from August 5, 1959, to August 13, 1959, and that death occurred at 7:50 P. M., from the causes and on the date stated above. ACTUAL SIGNATURE <i>John W. Crawford, M.D.</i> ADDRESS (Street, city or town, state) PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, M.D. DATE SIGNED 8/14/59 | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 8/18/59 | | 22c. NAME OF CEMETERY OR CREMATORIUM Baltimore National Cemetery | | 22d. LOCATION (City, town, or county) Baltimore, Maryland | | (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Arlington S. Phillips, 1808 N. Monroe St. Balto 17 | | ADDRESS | | 24a. REC'D BY REGISTRAR Date 8/17/59 | | 24b. REGISTRAR'S SIGNATURE <i>Arlington S. Phillips</i> | | | |



TO HOSPITAL OR
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8896

CERTIFICATE OF DEATH

Reg. Dist. No.

08867

| | | | | |
|--|---|---|--|----------------------|
| 1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md</i> | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i> | | b. COUNTY <i>Baltimore</i> | | |
| c. LENGTH OF STAY IN 1b <i>10 yrs</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i> | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>611 Alleghany Ave</i> | | d. STREET ADDRESS <i>611 Alleghany Ave</i> | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print) | First <i>WILLIAM</i> | Middle <i>OLIVER</i> | Last <i>SMITH JR</i> | |
| 4. DATE OF DEATH | Month <i>8</i> | Day <i>12</i> | Year <i>1959</i> | |
| 5. SEX <i>M</i> | 6. COLOR OR RACE <i>W</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>Apr 30 1882</i> | |
| 9. AGE (In years last birthday) <i>77 yrs</i> | 10. IF UNDER 1 YEAR Months <i>7</i> | 11. IF UNDER 24 HRS Days <i>0</i> | 12. IF UNDER 24 HRS Hours <i>0</i> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Clergyman</i> | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) <i>Baltimore Md</i> | 12. CITIZEN OF WHAT COUNTRY? <i>Baltimore Md</i> | |
| 13. FATHER'S NAME <i>Wm O Smith</i> | 14. MOTHER'S MAIDEN NAME <i>Anna Larrimore</i> | Address <i>Mrs Bernard Schloss Stevenson Md</i> | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>2</i> | 16. SOCIAL SECURITY NO. | 17. INFORMANT <i>P. A. B. S. S.</i> | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>PNEUMONIA</i> | |
| Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO <i>MULTIPLE MYELOMA</i> | | INTERVAL BETWEEN ONSET AND DEATH <i>24 HRS.</i> | | |
| (c) DUE TO <i>8 mos.</i> | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | |
| 20c. TIME OF INJURY Hour a. m. p. m. | Month <i>Aug</i> | Day <i>13</i> | Year <i>1959</i> | |
| 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) <i>Baltimore</i> | (County) <i>Baltimore</i> | (State) <i>Md</i> |
| 21. I certify that I attended the deceased from <i>8-11-59</i> , 19 <i>59</i> , to <i>7-31-59</i> , 19 <i>59</i> , and that death occurred at <i>5:30</i> A.M., from the causes and on the date stated above | ADDRESS (Street, city or town, state) <i>Carlton L. Sexton</i> | | DATE SIGNED | |
| ACTUAL SIGNATURE <i>Carlton L. Sexton</i> | M.D. | | | |
| PHYSICIAN'S NAME (Type) <i>CARLTON L. SEXTON</i> | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial Aug 13/59</i> | 22b. DATE THEREOF <i>Aug 13/59</i> | 22c. NAME OF CEMETERY OR CREMATORIAL <i>Woodlawn</i> | 22d. LOCATION (City, town, or county) <i>Baltimore</i> | (State) <i>Md</i> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Henry W. Jenkins</i> | ADDRESS <i>Ames 44905 York</i> | 24a. REC'D BY REGISTRAR <i>DAW 14 '59</i> | 24b. REGISTRAR'S SIGNATURE <i>Caroline S. Knapp</i> | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

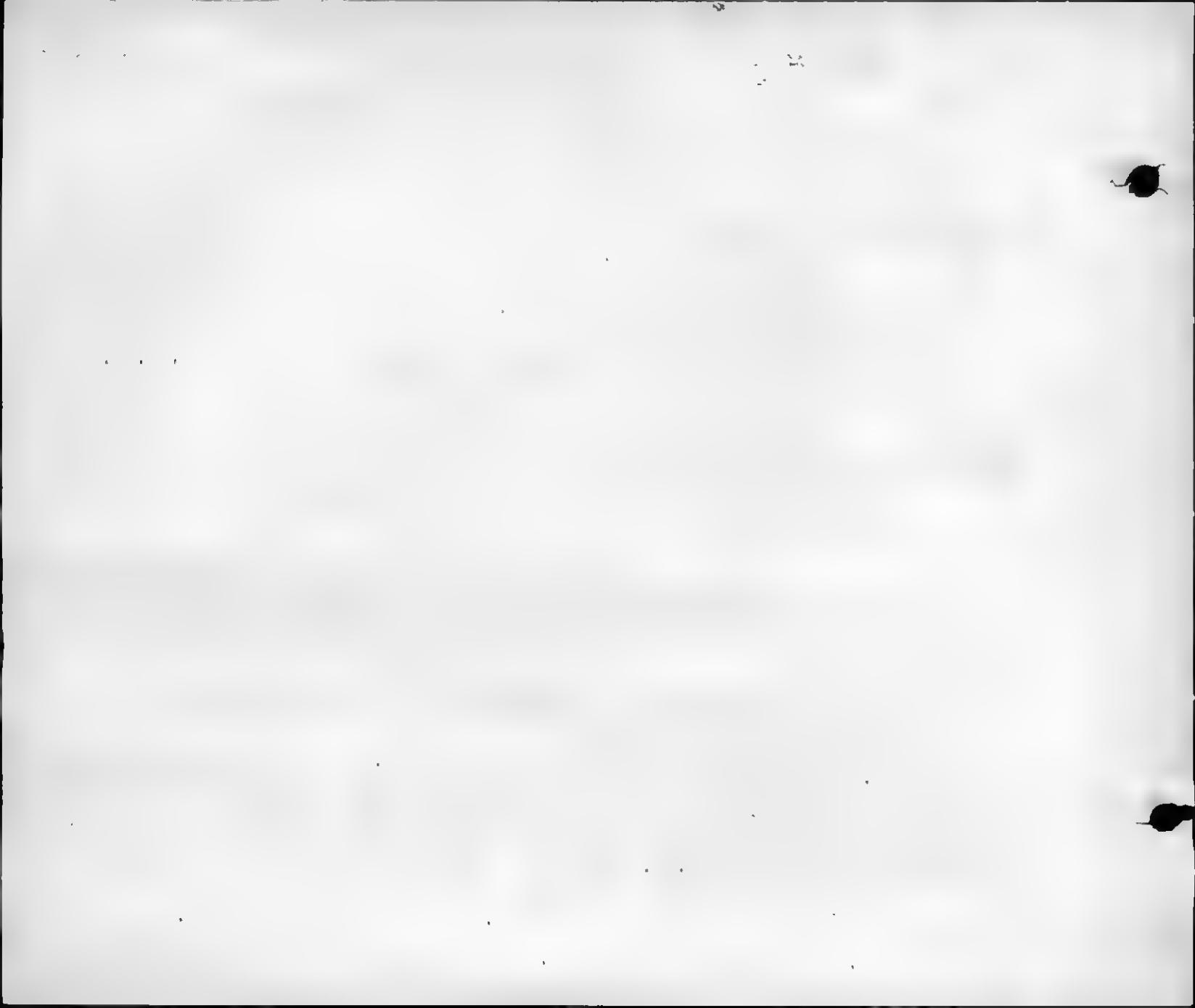
8897

CERTIFICATE OF DEATH

08868

Reg. Dist. No.

| | | | | | | | |
|--|---------------------------|--|------------------------------------|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland | | b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | c. LENGTH OF STAY IN 1b 13yr2mth5dys | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | | 24.1.4 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL | | d. STREET ADDRESS 701 McHenry Street | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) John | | First T. | Middle T. | 4. DATE OF DEATH Stamp | Month August | Day 26 | Year 1959 |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Sept. 14, 1878 | | 9. AGE (In years last birthday) 80 yrs. | 10. IF UNDER 1 YEAR Months | 11. IF UNDER 24 HRS Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) furniture finisher | | 10b. KIND OF BUSINESS OR INDUSTRY furniture | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY U. S. A. | |
| 13. FATHER'S NAME Thomas Stamp | | 14. MOTHER'S MAIDEN NAME Annie ? | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown | | 16. SOCIAL SECURITY NO. 216-12-5889 | | 17. INFORMANT Records: SPRING GROVE STATE HOSPITAL | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Generalized arteriosclerosis (c) | | Arteriosclerotic cardiovascular disease | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | Ulcer of stomach | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from July 22, 1959, to Aug. 26, 1959, that I last saw the deceased alive on Aug. 26, 1959, and that death occurred at 11:52 A.M. from the causes and on the date stated above | | | | | | | |
| ACTUAL SIGNATURE Stella Wachsler | | M.D. | | ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL 8-26-59 | | DATE SIGNED | |
| PHYSICIAN'S NAME (Type) Stella Wachsler, M. D. | | Catonsville 28, Maryland | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 8/29/59 | | 22c. NAME OF CEMETERY OR CREMATORIUM Mt Olivet Cem. | | 22d. LOCATION (City, town, or county) Baltimore, Md. (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck 5305 Harford Rd. | | ADDRESS | | 24a. REC'D BY REGISTRAR DATE AUG 28 '59 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8898

CERTIFICATE OF DEATH

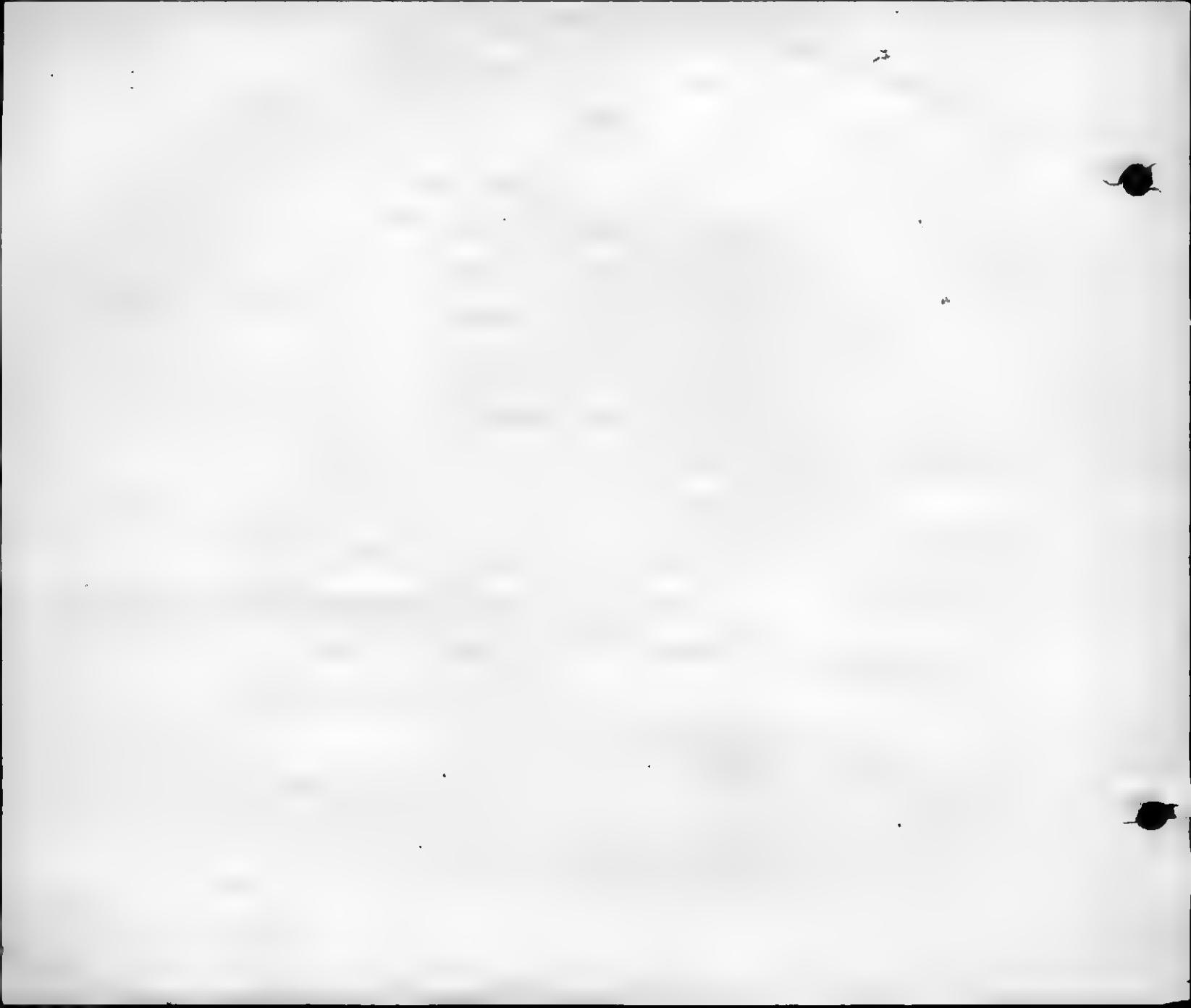
08869

Reg. Dist. No.

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|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|-----------------------------|--|
| 1. PLACE OF DEATH a. COUNTY | | Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) | | | | | | | | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. LENGTH OF STAY IN lb | | a. STATE Maryland b. COUNTY | | | | | | | | | | | | | |
| Catoonsville | | 11y. 4m. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | | | | | | | | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS | | 3. NAME OF DECEASED (First Middle Last) | | | | | | | | | | | | | |
| Spring Grove State Hospital | | 1704 Fleet Street | | William Stefanowski | | | | | | | | | | | | | |
| 5. SEX | | 6. COLOR OR RACE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH | | 9. AGE (In years last birthday) yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 11. KIND OF BUSINESS OR INDUSTRY | | 12. BIRTHPLACE (State or foreign country) | | 13. CITIZEN OF WHAT COUNTRY | |
| Male | | 11 | | WIDOWED <input type="checkbox"/> | | Feb. 14 1872 | | 87 | | Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY | | Germany | | Germany | |
| 14. FATHER'S NAME | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | 19. WAS AUTOPSY PERFORMED? (Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>) | | | | | | | |
| Matthew Stefanovsky | | No | | 160-10-0000 | | Book, Records of Spring Grove St. Hosp. | | PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | 19. WAS AUTOPSY PERFORMED? (Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>) | | | | | |
| work. | | (b) (c) | | DUE TO | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | 19. WAS AUTOPSY PERFORMED? (Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>) | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | DUE TO | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | 19. WAS AUTOPSY PERFORMED? (Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>) | | | | | | | |
| 19. MEDICAL CERTIFICATION | | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY Month, Day, Year | | 20d. INJURY OCCURRED | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | | |
| ACTUAL SIGNATURE | | 21. I certify that I attended the deceased from _____ to _____, that I last saw the deceased alive on _____, and that death occurred at _____, from the causes and on the date stated above. | | 21. I certify that I attended the deceased from _____ to _____, that I last saw the deceased alive on _____, and that death occurred at _____, from the causes and on the date stated above. | | 21. I certify that I attended the deceased from _____ to _____, that I last saw the deceased alive on _____, and that death occurred at _____, from the causes and on the date stated above. | | 21. I certify that I attended the deceased from _____ to _____, that I last saw the deceased alive on _____, and that death occurred at _____, from the causes and on the date stated above. | | 21. I certify that I attended the deceased from _____ to _____, that I last saw the deceased alive on _____, and that death occurred at _____, from the causes and on the date stated above. | | 21. I certify that I attended the deceased from _____ to _____, that I last saw the deceased alive on _____, and that death occurred at _____, from the causes and on the date stated above. | | | | | |
| PHYSICIAN'S NAME (Type) | | 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORIAL | | 22d. LOCATION (City, town, or county) (State) | | | | | | | | | |
| BRUNO RADANSKY | | Burial | | 8/26/59 | | Cathedral | | Baltimore | | | | | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | | 24a. REC'D BY REGISTRAR | | 24b. REGISTRAR'S SIGNATURE | | | | | | | | | | | |
| J. J. Foley Sons | | 1316 Light St | | DATE AUG 31 '59 | | Arthur & Kline | | | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8899

CERTIFICATE OF DEATH

Reg. Dist. No.

08870

| | | | | | | | | |
|--|----------------------------------|---|--------------------------|--|--|---|------------------|---------------------|
| 1. PLACE OF DEATH a. COUNTY BALTIMORE | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND | | b. COUNTY BALTIMORE | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE | | c. LENGTH OF STAY IN 1b LIFE | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X BALTIMORE | | d. STREET ADDRESS 1906 REDWOOD AVE. | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1906 REDWOOD AVE. | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print) ROSALIE | | First A. | Middle STEVENS | Last | 4. DATE OF DEATH AUGUST 14 | Month AUGUST | Day 14 | Year 1959 |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | B. DATE OF BIRTH SEPT. 22-1890 | 9. AGE (In years lost birthday) 68 yrs. | IF UNDER 1 YEAR Months Days Hours Min | IF UNDER 24 HRS | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMADY | | 10b. KIND OF BUSINESS OR INDUSTRY AVON COSMETICS | | 11. BIRTHPLACE (State or foreign country) BALT., CO., MD. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME NAYSMITH | | | | 14. MOTHER'S MAIDEN NAME ELIZABETH HOPKINS | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. 215-32-8991 | | INFORMANT WALTER C. STEVENS | | Address 1906 REDWOOD AVE. | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Urolithia DUE TO 199.2 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Diffuse abdominal metastases (c) Undifferentiated adenocarcinoma, rectum DUE TO 6 months 6 months INTERVAL BETWEEN ONSET AND DEATH 3 days | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b) | | | | | | |
| 20c. TIME OF INJURY Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that I attended the deceased from 8/1/59 , 19, to 8/14/59 , 19, that I last saw the deceased alive on 8/14/59 , 19, and that death occurred at 8:16 PM , from the causes and on the date stated above. ACTUAL SIGNATURE Dale Van Leenen MD | | ADDRESS (Street, city or town, state) BALTO. MD. | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 8-18-1959 | | 22c. NAME OF CEMETERY OR CREMATORIAL GOVANS PRES. CEM. | | 22d. LOCATION (City, town, or county) (State) BALTO. MD. | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Zassahn Funeral Home 7401 Belair Rd. | | ADDRESS | | 24a. REC'D BY REGISTRAR DATE AUG 18 '59 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Price | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trouss permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 filmG248 9-11-59 et

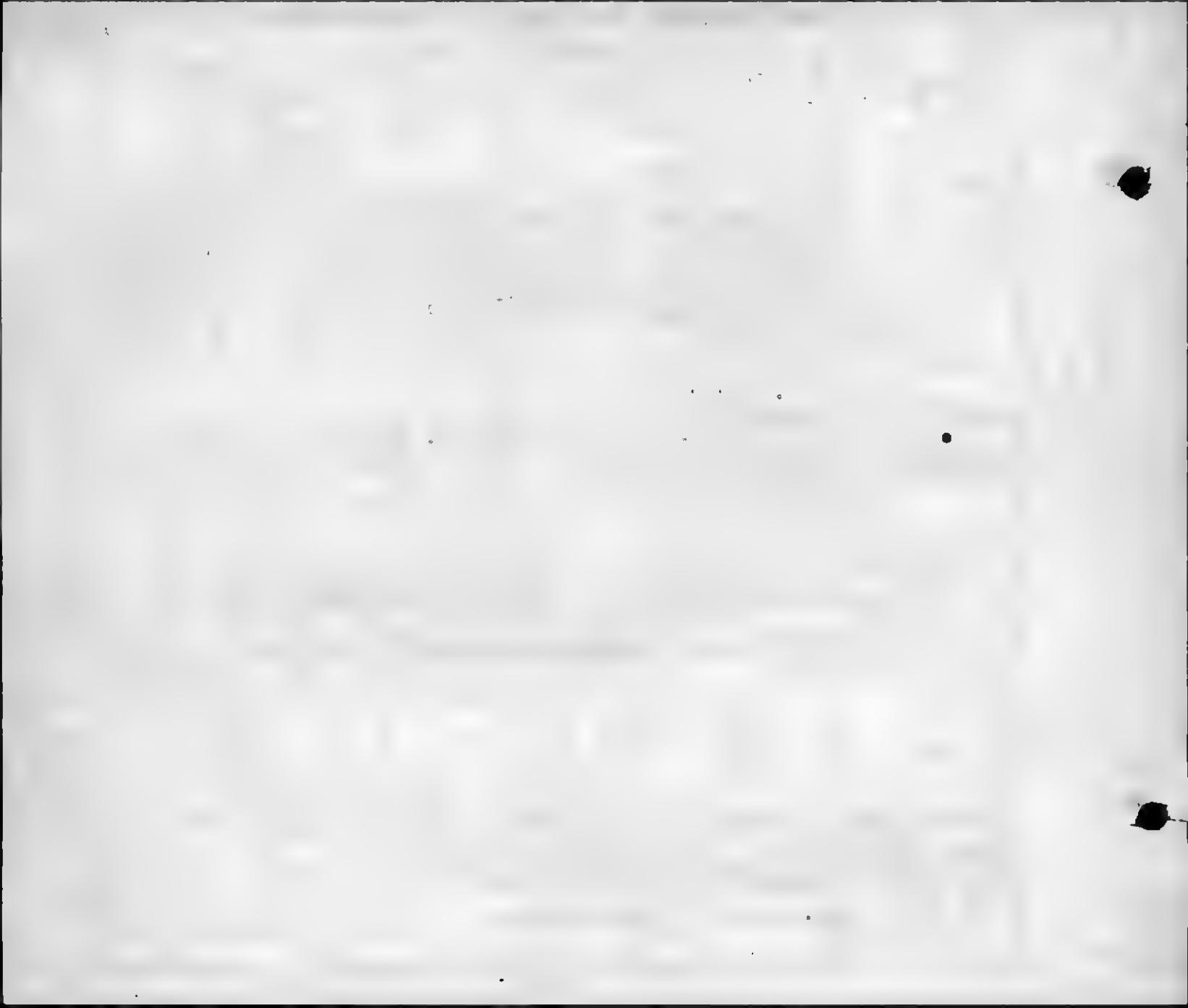
8909

CERTIFICATE OF DEATH

Reg. Dist. No.

08871

| | | | |
|---|---------------------------|---|------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Baltimore | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (Rural) | | b. COUNTY Baltimore | |
| c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (Rural) Lutherville | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Caton Ridge Nursing Home | | d. STREET ADDRESS Harrowgate 9 Alston Road | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First MINNIE | | Middle AUGUSTA | Last STIEFEL |
| 4. DATE OF DEATH August 22, | | Month | Day Year 19 59 |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH March 26, 1885 |
| 9. AGE (in years last birthday) 74 yrs | | 10. IF UNDER 1 YEAR Months | 11. IF UNDER 24 HRS. Hours Min |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 10c. BIRTHPLACE (State or foreign country) Maryland | | 11. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Hamelil R. Hirschman | | 14. MOTHER'S MAIDEN NAME Ida Miller | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 17. INFORMANT 218-03-7827D Conrad E. Stiefel, 9 Alston Rd. Lutherville | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. | | INTERVAL BETWEEN ONSET AND DEATH 30 days | |
| (b) DUE TO monitari | | 8 month | |
| (c) DUE TO Aged - arterio sclerotic 'gandy' | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>8/13</u> 1959 to <u>8/22</u> 1959, that I last saw the deceased alive on <u>8/17</u> 1959, and that death occurred at <u>7:30</u> A.M., from the causes and on the date stated above. ACTUAL SIGNATURE <u>Cliff Ratliff Jr.</u> M.D. ADDRESS (Street, city or town, state) <u>4605 E. 36th St. Baltimore, Md.</u> DATE SIGNED <u>8/25/59</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Aug. 25, 1959 | |
| 22c. NAME OF CEMETERY OR CREMATORIAL Lorraine Park | | 22d. LOCATION (City, town, or county) Baltimore (State) Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Towson, Inc. 1050 York Rd. Towson | | 24a. REC'D BY REGISTRAR DATE AUG 25 '59 | |
| ADDRESS Md. | | 24b. REGISTRAR'S SIGNATURE <u>Cliff Ratliff Jr.</u> | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8901

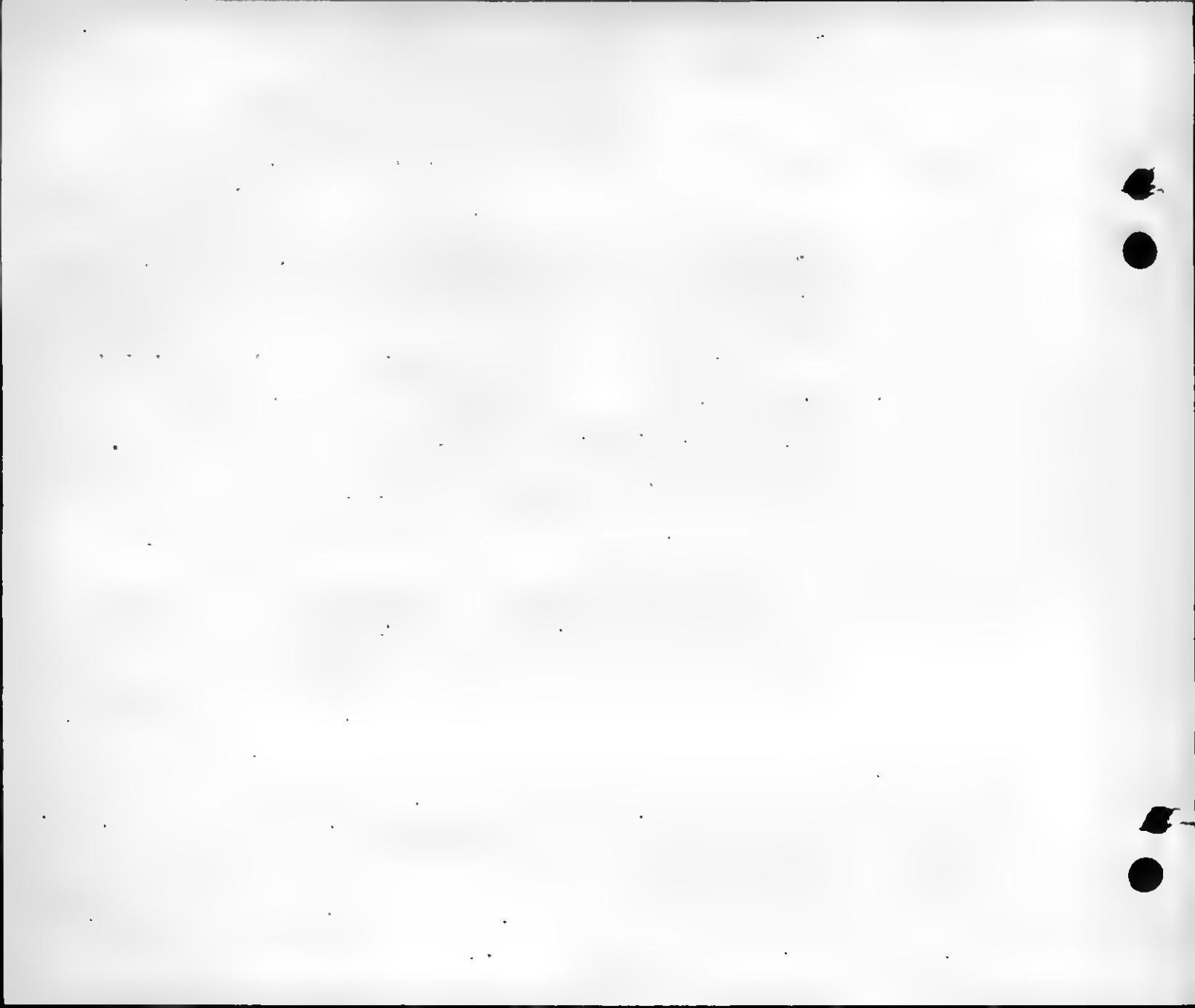
CERTIFICATE OF DEATH

Reg. Dist. No. 108872

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours of death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Monkton rural | | c. LENGTH OF STAY IN 1b 18 years | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Monkton rural | |
| 3. NAME OF DECEASED (Type or print) James Howard Swift | | First James | Middle Howard |
| 4. DATE OF DEATH Aug. 31, 1883 | Month Aug. | Day 15 | Year 1959 |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH Aug. 31, 1883 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY Farm Owner | |
| 11. BIRTHPLACE (State or foreign country) Harford County Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME William Thomas Swift | | 14. MOTHER'S MAIDEN NAME Emma Louise Harman | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 217-36-2685 | |
| 17. INFORMANT W. Lewis Swift | | Address Monkton, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Cerebral Vascular accident.</i> <i>Arterio sclerotic Cardi Vascular Disease</i> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Congestive Heart Failure & Pneumonia</i> | |
| 20c. TIME OF INJURY Hour a. m. 10 45 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) Monkton | |
| | | (County) Baltimore (State) Md. | |
| 21. I certify that I attended the deceased from 8-15 , 19 59 , to 8-15 , 19 59 , that I last saw the deceased alive on 8-15 , 19 59 , and that death occurred at 10 45 A.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE C. Herbert Mueller Jr. | | ADDRESS (Street, city or town, state) Harford, Monkton, Md. | |
| DATE SIGNED 8/15/59 | | | |
| PHYSICIAN'S NAME (Type) C. HERBERT MUELLER, Jr. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 8/18/1959 | |
| 22c. NAME OF CEMETERY OR CREMATORIAL Wesley Chapel | | 22d. LOCATION (City, town, or county) (State) Monkton, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Furtz, Jarrettsville, Md. | | 24a. REC'D BY REGISTRAR DATE AUG 18 '59 | |
| | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kline | |



FOR STATE
HEALTH DEPT.

TO DEFENDANT EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMJ. Page 5 may be retained by our files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8904

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08876

Reg. Dist. No.

| | | | | | | | |
|--|--|--|--|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY | BALTIMORE MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MD. | b. COUNTY BALTO. | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | SAME AS DE | | | c. LENGTH OF STAY IN 1b 80 YRS | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE MARYLAND | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 511 S. 48TH ST. | | | | d. STREET ADDRESS 511 S. 48TH ST. | | | e. IS PERSON DECEASED ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) | First | Middle | Last | 4. DATE OF DEATH 1 - 13 1959 | Month | Day | Year |
| 3. SEX F | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1-9-1873 | 9. AGE (in years on birthday) 86 yrs. | 10. IF UNDER 1 YEAR Months | 11. IF UNDER 24 HRS Days | 12. IF UNDER 24 HRS Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10b. KIND OF BUSINESS OR INDUSTRY HOME | | 11. BIRTHPLACE (State or foreign country) POLAND | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME JOHN KUZLOWSKI | | 14. MOTHER'S MAIDEN NAME UNKNOWN | | Address HELEN KRIS 511 S. 48TH ST. | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | | | | | | |
| 16. SOCIAL SECURITY NO. | | | | | | | |
| 17. INFORMANT | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) PERNICOUS ANEMIA. SENILITY. | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) ONE | | | | | | | |
| 20c. TIME OF INJURY Hour a. m. p. m. | Month, Day, Year 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE M. B. Davis | EXAMINER'S NAME (Type) M. B. Davis MD | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | DATE SIGNED 8/14/59 | | |
| 22a. BURIAL CREMATION REMOVAL (Specify) BURIAL | 22b. DATE THEREOF 8-17-59 | 22c. NAME OF CEMETERY OR CREMATORIAL SACRED HEART OF MARY | 22d. LOCATION (City, town, or county) BALTIMORE | (State) | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Walter Debruska 1001 Dundalk Ave | ADDRESS | 24a. REC'D. BY REGISTRAR AUG 19 '59 | 24b. REGISTRAR'S SIGNATURE Colin S. Kinnaird | | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the funeral director or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS A15M
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8902 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08873

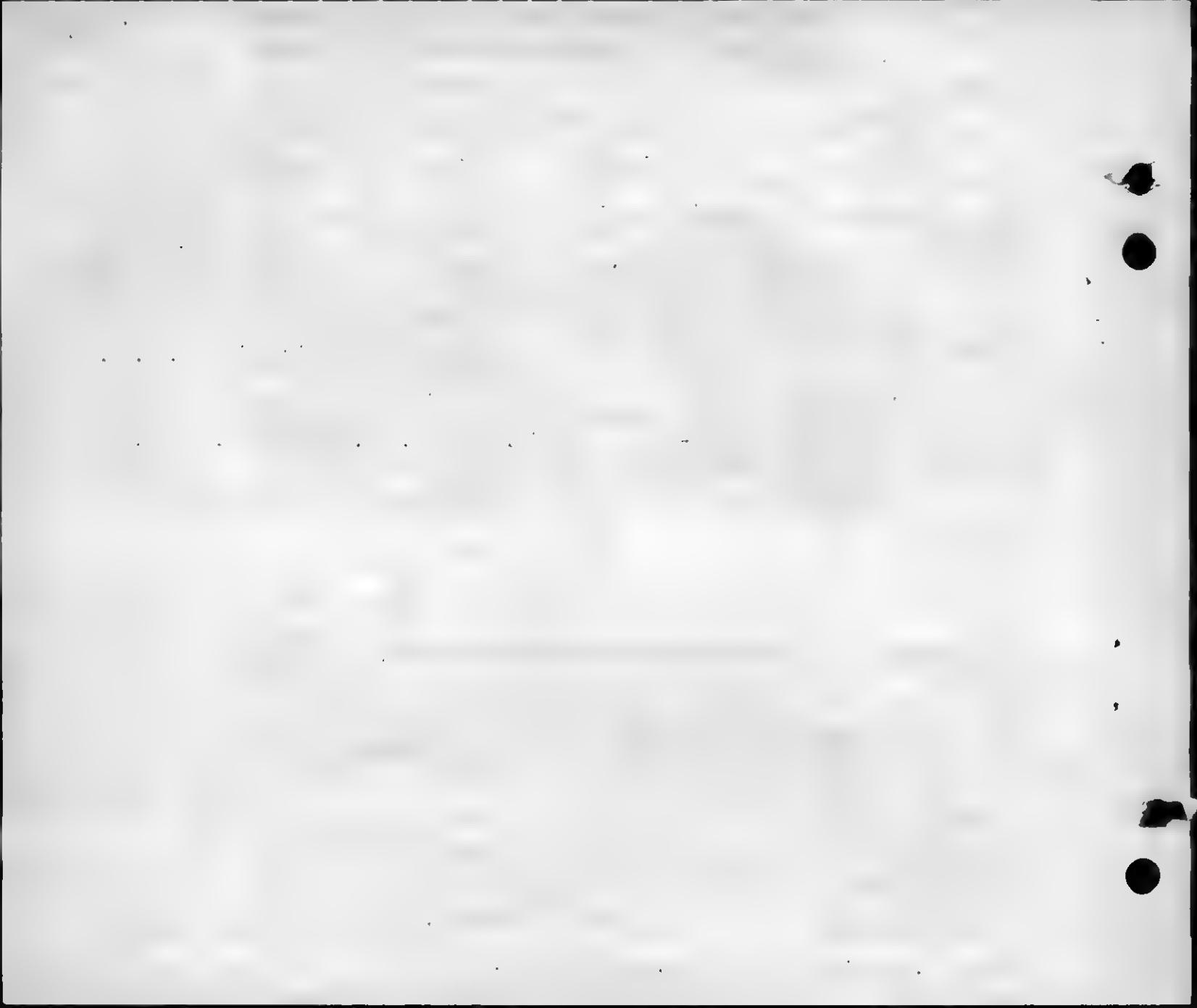
Reg. Dist. No.

| | | | | | | |
|---|--|---|--|---------------------|----------|---------|
| 1. PLACE OF DEATH a. COUNTY Baltimore | MARYLAND | 2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland b. COUNTY Baltimore | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Grey Manor | c. LENGTH OF STAY IN 1b | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Grey Manor | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1123 Old North Point Road | d. STREET ADDRESS | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print) GEORGE LAMBERT TATE | First Middle Lest | 4. DATE OF DEATH August 7, 1959 | | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> August 5, 1883 | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Land scape gardener | 10b. KIND OF BUSINESS OR INDUSTRY | 9. AGE (in years last birthday) 76 yrs | | | | |
| 13. FATHER'S NAME ? Tate | 11. BIRTHPLACE (State or foreign country) Maryland | 12. IF UNDER 1 YEAR Months Days Hours Min | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No. | 16. SOCIAL SECURITY NO 212-26-3885 | 14. MOTHER'S MAIDEN NAME Don't know | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4d0.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b) A-S-C-U-Disease | 17. INFORMANT Russell Tate 24 N. Kresson St. | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Injury | | | | | |
| 20c. TIME OF INJURY Hour o. m. p. m. | Month, Day, Year 19 | 20d. INJURY OCCURRED While at work Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | |
| ACTUAL SIGNATURE M. B. DAVIS | M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED 8/9/59 | | | |
| 220. BURIAL, CREMATION REMOVAL (Specify) Burial | 221. DATE THEREOF 8/10/59 | 222. NAME OF CEMETERY OR CEMETORY Oak Lawn Cemetery | 223. LOCATION (City, town, or county) Colgate, Md. | (State) | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home 2112 Dundalk Ave. | ADDRESS | 24a. REC'D BY REGISTRAR DATE AUG 12 1959 | 24b. REGISTRAR'S SIGNATURE Arthur S. Thomas | | | |



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If one delay is necessary, please enclose certificate, writing the word "pending", in pencil in item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMJ. Page 5 may be retained for files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

| MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 | | | | | | | | | | Reg. Dist. No. 08874 | |
|---|--|--|---|---|---|---|--|--|---------|---|--|
| 8903 MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkridge (Baltimore 27) d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 5448 Race Road | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN lb 370 Days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital | | | | | e. STREET ADDRESS | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) CHARLES | | First A. Middle TAYLOR, JR | | Last | | 4. DATE OF DEATH | | Month August Day 12 Year 1959 | | | |
| 5. SEX Male | | 6. COLOR OR RACE Colored | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH | | 9. AGE (in years last birthday) 49 yr. | | IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0 IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Freight Handler | | 10b. KIND OF BUSINESS OR INDUSTRY Trucking Company | | 11. BIRTHPLACE (State or foreign country) Buffalo Springs, Virginia | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | | | | |
| 13. FATHER'S NAME Charles A. Taylor, Sr. | | | | | 14. MOTHER'S MAIDEN NAME Nora MN: Newton | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes <small>(If yes, give war or dates of service)</small> | | | 16. SOCIAL SECURITY NO. 215-14-8640 | | | 17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland | | | Address | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rheumatic heart disease 416X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | | | | | | |
| 20c. TIME OF INJURY Hour a. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | | (County) | | (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE W. Bradley King, Jr. | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | | Aug. 12, 1959 | |
| | | | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 8-14-59 | | 22c. NAME OF CEMETERY OR CREMATORIAL Baltimore National Cem. | | | | 22d. LOCATION (City, town, or county) Baltimore (State) Maryland | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Samuel W. Sullivan, Jr. 1011 N. Arlington Ave. | | | | | | | | | | ADDRESS | |
| VS. A15ME(S) 5M 9/55 | | | | | | | | | | 24a. REC'D BY REGISTRAR Aug 14 '59 | |
| | | | | | | | | | | 24b. REGISTRAR'S SIGNATURE Arthur E. King | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE: 18

ITEMS 3, -1 from G-246 8-1-59 etc

08875

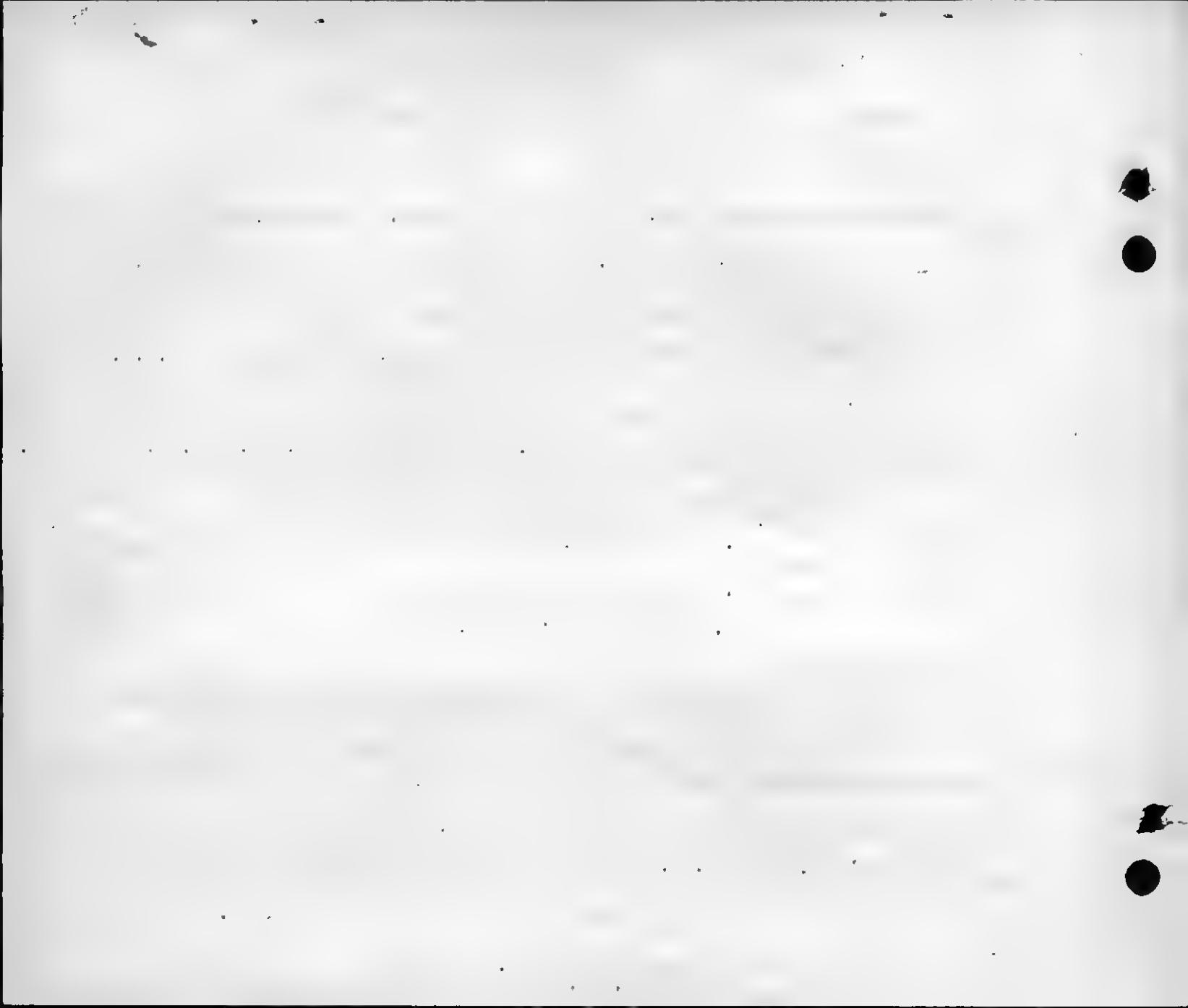
Reg. Dist. No.

| | | | | | | | | |
|--|----------------------------------|---|--|--|---|--|--------------------------------------|---------------------|
| 1. PLACE OF DEATH a. COUNTY Baltimore | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard | | c. LENGTH OF STAY IN lb 42 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | | d. STREET ADDRESS 1912 W. Lombard Street | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print) WILLIAM | | First W. | Middle J. | Last TAYLOR | 4. DATE OF DEATH August 8, 1959 | Month August | Day 8 | Year 1959 |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH July 14, 1901 | 9. AGE (In years last birthday) 58 yrs | IF UNDER 1 YEAR Months 0 | | IF UNDER 24 HRS Hours 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sheet Metal Worker | | 10b. KIND OF BUSINESS OR INDUSTRY Factory | | 11. BIRTHPLACE (State or foreign country) Uniontown, Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | | |
| 13. FATHER'S NAME EDWIN TAYLOR | | | | 14. MOTHER'S MAIDEN NAME MAY WARD | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES | | 16. SOCIAL SECURITY NO WW I | | 17. INFORMANT CLIN. RECORDS FOLDER, VET. ADM. HOSP. FT. HOWARD, MD | | Address | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE PANCREATITIS | | | | INTERVAL BETWEEN ONSET AND DEATH 43 DAYS | | | | |
| b. PERICARDITIS, ACUTE | | | | 1 WEEK | | | | |
| c. ABSCESSES OF LIVER AND KIDNEY | | | | 1 WEEK | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 4. MYOCARDIAL INFARCTION, ACUTE | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) VAH, FORT HOWARD, MARYLAND | | (County) 8/8/59 | | (State) |
| 21. I certify that VAH attended the deceased from June 27, 1959 to August 8, 1959 and that death occurred at 6:15 P.M. from the causes and on the date stated above. | | | | | | | | |
| ACTUAL SIGNATURE Clyde B Cope | | M.D. | | ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND | | DATE SIGNED 8/8/59 | | |
| PHYSICIAN'S NAME (Type) CLYDE B. COPE, M. D. | | VAH, FORT HOWARD, MARYLAND | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 8-12-59 | | 22c. NAME OF CEMETERY OR CREMATORIUM Baltimore National | | 22d. LOCATION (City, town, or county) Baltimore, Md. | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook - Blight Lure | | ADDRESS 6009 Harford Rd. | | 24a. REC'D BY REGISTRAR Clyde S. Kruus | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kruus | | |
| Wm Cook - Blight Lure Blight Funeral Home, Baltimore, Md. | | ADDRESS 6009 Harford Rd. | | DATE AUG 11 '59 | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-in-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

VS A15 (4)
15M 10/57



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in one of the two within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. ATIME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8906 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08877

Reg. Dist. No.

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Woodlawn | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3519 Sussex Road | | d. STREET ADDRESS 3519 Sussex Road | |
| e. IS RESIDENT ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Arthur Randolph Randolph | | 4. DATE OF DEATH Month Day Year August 15 1959 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> July 25 1959 | 9. AGE (In years last birthday) yrs. Months Days Hours Min. 21 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | 10c. BIRTHPLACE (State or foreign country) Wash. D. C. |
| 13. FATHER'S NAME Unknown | | 14. MOTHER'S MAIDEN NAME Unknown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — | | 16. SOCIAL SECURITY NO. — | 17. INFORMANT Board of Child Care 516 N. Charles St Address |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DUE TO (b) DUE TO (c) | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour a. m. p. m. | Month, Day, Year 19 | 20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) W. Bradley King, Jr., M.D. | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED 8/15/59 |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF Aug. 17, 1959 | 22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Meadowridge Memorial 8728 Liberty Rd. | 22d. LOCATION (City, town, or county) (State) Dorsey Maryland |
| 23. FUNERAL DIRECTOR'S SIGNATURE Loring Byers Funeral Hom | | 24a. REC'D BY REGISTRAR DATE SEP 8 '59 | 24b. REGISTRAR'S SIGNATURE Collins & Frazee |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8907 CERTIFICATE OF DEATH

06878

Reg. Dist. No.

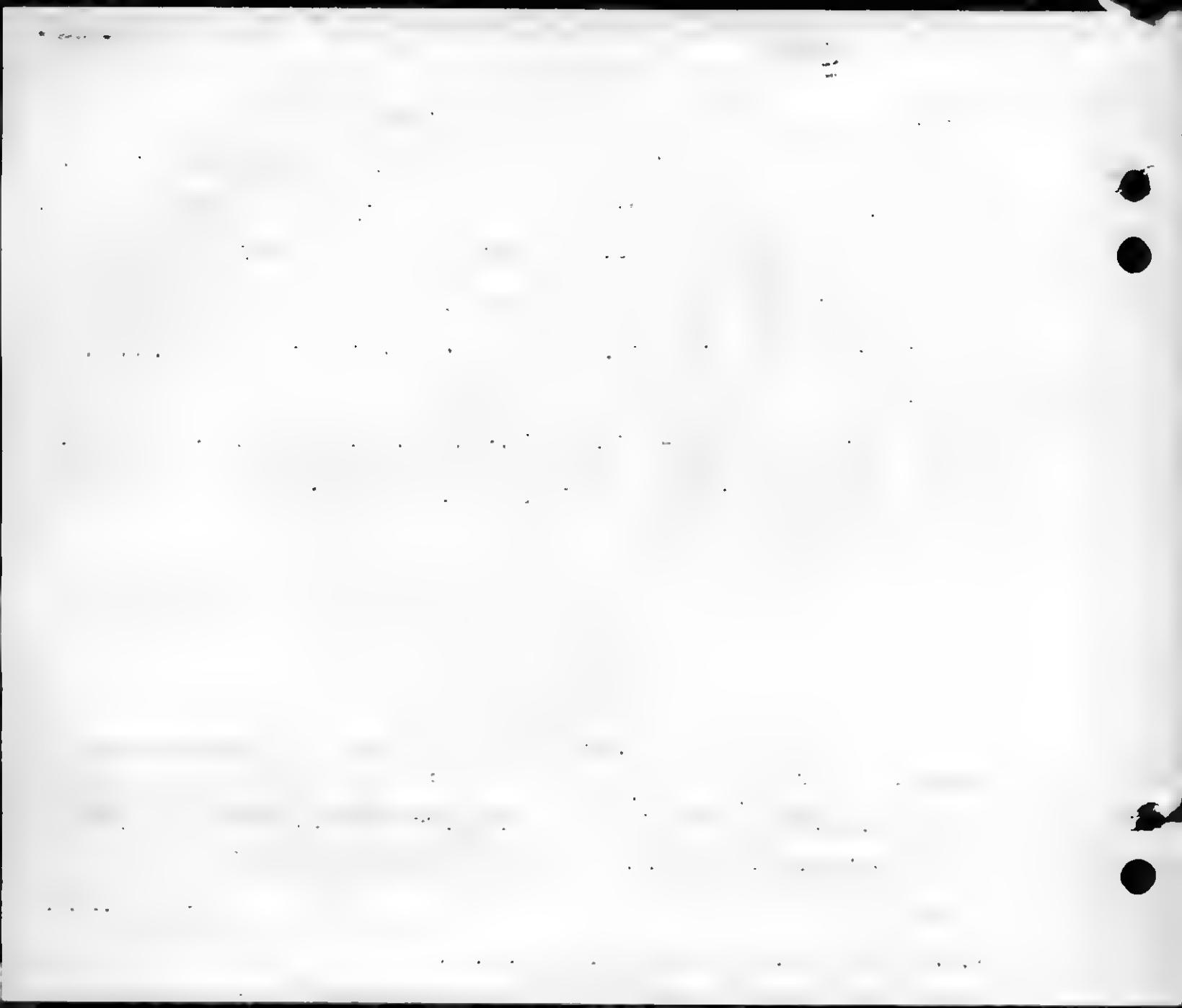
| | | | | | | | | |
|--|--|---|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore | | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard | | | c. LENGTH OF STAY IN 1b 102 Days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 4 909 Woodlyn Road, Baltimore 21, Md. | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital | | | d. STREET ADDRESS 909 Woodlyn Road (21) | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) | First LEE | Middle --- | Last TRIPPLETT | 4. DATE OF DEATH August | Month 7 | Day 19 | Year 59 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH June 28, 1925 | 9. AGE (In years last birthday) 34 | 10. IF UNDER 1 YEAR Months 0 | Days 0 | 11. IF UNDER 24 HRS Hours 0 | Min. 0 |
| 10a. USAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician | | 10b. KIND OF BUSINESS OR INDUSTRY Yacht Co. | | 11. BIRTHPLACE (State or foreign country) Lenoir, North Carolina | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | |
| 13. FATHER'S NAME Joe Triplett | | | | 14. MOTHER'S MAIDEN NAME Lola Pope | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | | 16. SOCIAL SECURITY NO. 243-22-8922 | | INFORMANT Clin. Rec., Vet. Adm. Hospital, Fort Howard, Md. | Address | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF LUNG, RIGHT, WITH METASTASIS | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH UNKNOWN |
| DUE TO Condition, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) DUE TO (c) | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that attended the deceased from April 27, 1959 , to August 7, 1959 , and last seen the deceased and that death occurred at 2:40 A.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) | | | | | | | | |
| ACTUAL SIGNATURE <i>John W. Crawford</i> | M.D. VAH, FORT HOWARD, MARYLAND | | | | | | DATE SIGNED 8/7/59 | |
| PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, M.D. | VAH, FORT HOWARD, MARYLAND | | | | | | | |
| 22a. BURIAL, CREMATION REMOVAL (Specify) Removal | 22b. DATE THEREOF 8-7-59 | 22c. NAME OF CEMETERY OR CREMATORIAL Church | | | 22d. LOCATION (City, town, or county) Caldwell Co., N.C. | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight, Inc., 6009 Harford R., Balto. 14, Md. | | | | ADDRESS | | 24a. REC'D BY REGISTRAR DATE AUG 11 '59 | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |

O HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be signed by the hospital or attending physician.

O FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

VS A15 (4)
1CM 9/SB

SHIPPED TO: Greer Funeral Home, 300 West Ave., Lenoir, N.C.



FOR STATE
HEALTH DEPT.

TO DEATH EXAMINER: This certificate should be executed within 24 hours after death. If any entry is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH2. Page 5 may be joined for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health as its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8908 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08879

Reg. Dist. No.

| | | | | | | | |
|--|--|-----------------------------------|--|---|--|---------------------------------------|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Baltimore | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Frederick | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills | | | | c. LENGTH OF STAY IN 1b 6 hrs. | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Gwynbrook Lane | | | | d. STREET ADDRESS Rt. 1 | | | |
| e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) | | First Carrie | Middle Virginia | Last Turner | 4. DATE OF DEATH | Month Aug. | Year 28 19 59 |
| 5. SEX Female | | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Nov. 15, 1892 | 9. AGE (In years last birthday) 66 yrs | 10. IF UNDER 1 YEAR Months Days | 11. IF UNDER 24 HRS Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | 11. BIRTHPLACE (State or foreign country) Frederick Co., Md. | | | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME Lewis Brown | | | | 14. MOTHER'S MAIDEN NAME Katherine Miller | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Tel. no. or unknown) no | | | | 16. SOCIAL SECURITY NO. 17. INFORMANT 174-20-2316 Mrs. Robt. Tiedemann, Gwynbrook Lane, Owings Mills, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | Address INTERVAL BETWEEN ONSET AND DEATH 3 mos. | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 156.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) | | | | Carcinoma of liver | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| none | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. none | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18) none | | | |
| 20c. TIME OF INJURY Hour o. m. p. m. | | Month, Day, Year none 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none | 20f. (City or town) none | (County) | (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE <i>C. E. McWilliams</i> | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) C. E. McWilliams, M. D. Acting | | | | DATE SIGNED 8-28-59 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Aug. 31 1959 | 22c. NAME OF CEMETERY OR CREMATORIUM Friends Creek Cemetery | 22d. LOCATION (City, town, or county) Frederick Co., Emmitsburg | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>C. E. Wilson</i> | | | | 24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE <i>Carlton S. Koenig</i> | | | |
| ADDRESS Emmitsburg, Md. | | | | DATE AUG 31 '59 | | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08880

8909

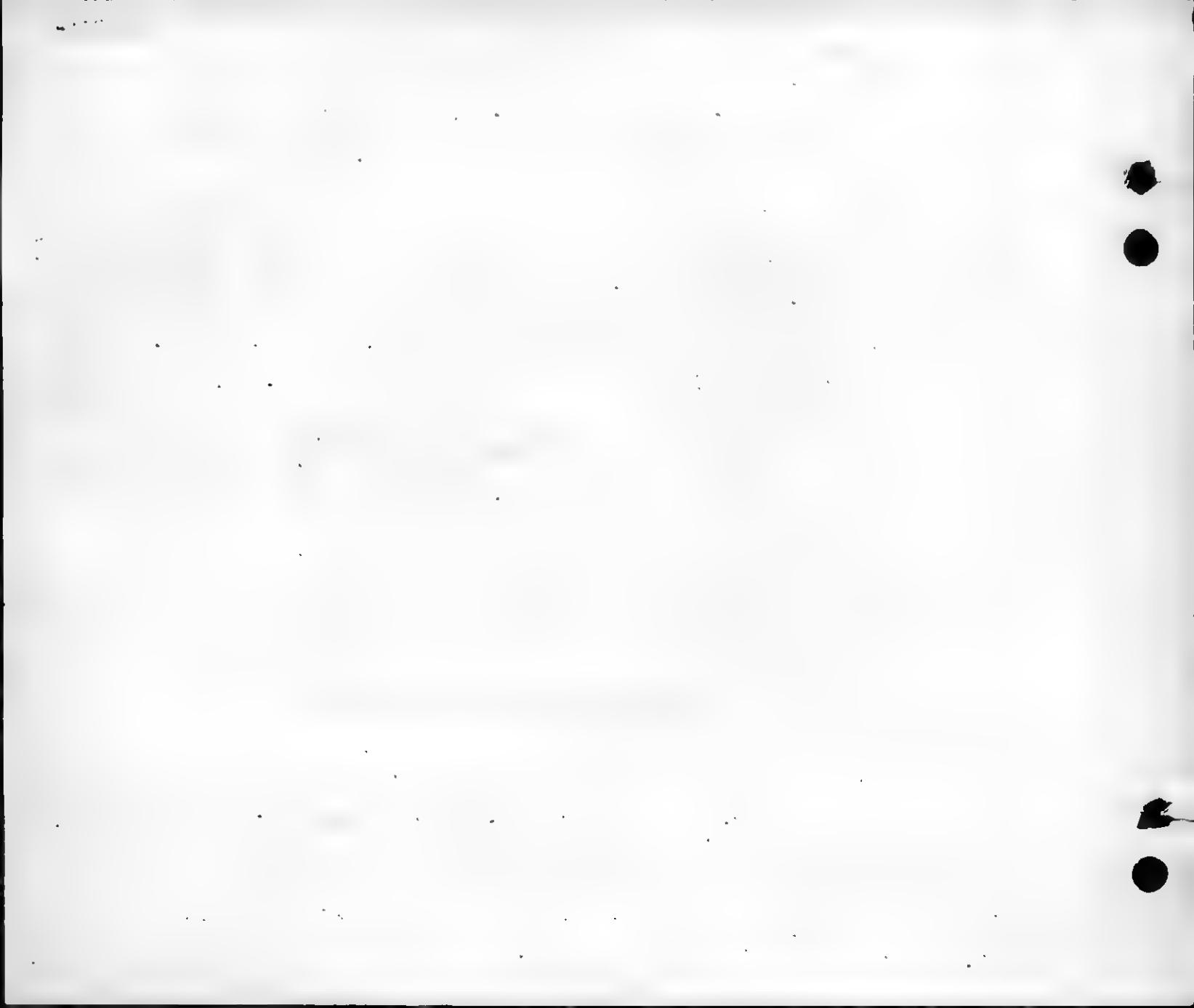
CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours of death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|--|--|--|---|
| 1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MARYLAND</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i> | | c. LENGTH OF STAY IN 1b <i>—</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Professional House</i> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <i>Rose</i> | | First <i>Rose</i> | Middle <i>Tyree</i> |
| 4. DATE OF DEATH <i>Aug. 12 1959</i> | | Last <i>—</i> | Month <i>Aug.</i> |
| 5. SEX <i>Female</i> | | 6. COLOR OR RACE <i>White</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 8. DATE OF BIRTH <i>1894</i> | | 9. AGE (In days or months since last birthday) <i>67</i> | 10. IF UNDER 1 YEAR Months <i>—</i> |
| 10a. USUAL OCCUPATION (Give kind of work done during most working life, even if retired) <i>Housewife</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>At Home</i> | 10c. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i> |
| 11. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 12. MOTHER'S MAIDEN NAME <i>Lois Mitznick</i> | |
| 13. FATHER'S NAME <i>Max Goldberg</i> | | 14. INFORMANT <i>Charles Goldberg - Same</i> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>—</i> | | 16. SOCIAL SECURITY NO. <i>—</i> | |
| 17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>HYPERNATRHEMIA - LEET WITH METABOLIC</i> | | INFORMANT Address <i>Charles Goldberg - Same</i> | |
| DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH <i>—</i> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i>—</i> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20c. TIME OF INJURY Month Day Year Hour o. m. p. m. <i>— 19 1959</i> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not white of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i> | | 20f. (City or town) (County) (State) <i>—</i> | |
| 21. I certify that I attended the deceased from <i>April 16, 1959</i> to <i>Aug. 12, 1959</i> , that I last saw the deceased alive on <i>Aug. 12, 1959</i> , and that death occurred at <i>1:30 P.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>—</i> | | ADDRESS (Street, city or town, state) <i>2320 Eastern Place, Baltimore, Md.</i> | |
| PHYSICIAN'S NAME (Type) <i>DANIEL SCHWARTZ</i> | | DATE SIGNED <i>8/13/59</i> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 22b. DATE THEREOF <i>8/14/59</i> | |
| 22c. NAME OF CEMETERY OR CREMATORIAL <i>Hebrew Burial Society</i> | | 22d. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Solo Lorraine & Barbara 1124 W. North Ave</i> | | 24a. REC'D BY REGISTRAR DATE AUG 17 '59 | |
| | | 24b. REGISTRAR'S SIGNATURE <i>Cathleen S. Kenna</i> | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08881

8910

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | |
|--|---------------------------|---|-----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6901 Petworth Road | | d. STREET ADDRESS 6901 Petworth Road #12 | | | |
| 3. NAME OF DECEASED (Type or print) First HELEN Middle MARJORIE Last VERNAY | | 4. DATE OF DEATH Month August Day 25 Year 1959 | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH Feb. 23, 1894 | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | | | |
| 13. FATHER'S NAME George J. Fairbank | | 14. MOTHER'S MAIDEN NAME Jessie G. White | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. None | | | |
| 17. INFORMANT Mr. Howard A. Vernay-6901 Petworth Road #12 | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | |
| BIL, BRONCHO PNEUMONIA & PLEURAL EFFUSION 3 yrs CHR. ATROPHIC ARTHRITIS 30 yrs | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>JCT. 1</u> , 19 <u>57</u> , to <u>Aug. 25</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Aug. 25</u> , 19 <u>59</u> , and that death occurred at <u>11:50 AM</u> , from the causes and on the date stated above. | | | | ADDRESS (Street, city or town, state) DATE SIGNED | |
| ACTUAL SIGNATURE <i>Robert F. Healy</i> | | M.D. | | 301 Mso. Hrs Bldg Bx 1 8/26/59 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 8/28/59 | | 22c. NAME OF CEMETERY OR CREMATORIUM Lorraine Park Cemetery | |
| 22d. LOCATION (City, town, or county) Baltimore, Maryland | | (State) | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm J. Tidener & Son</i> | | ADDRESS 3160-12 Md | | 24a. REC'D BY REGISTRAR DATE AUG 27 '59 | |
| | | | | 24b. REGISTRAR'S SIGNATURE <i>C. B. & T. Inc.</i> | |

TO HOSPITAL OR STANDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08882

8911

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission) a. STATE | |
| Baltimore MARYLAND | | Md BALTIMORE CITY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | |
| Year Amherst since 1950 | | Baltimore | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS | |
| Amherst Home | | 502 Woodlawn | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) | | First Middle Last | |
| Lillian Taylor Dickens | | 4. DATE OF DEATH | |
| 5. SEX | | 5. COLOR OR RACE | |
| Female White | | 6. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 7. DATE OF BIRTH | | 8. AGE (In years last birthday yrs.) | |
| Aug-30-1865 | | 9. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| None | | 11. BIRTHPLACE (State or foreign country) | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME | |
| U.S. | | Heram S. Taylor | |
| 14. MOTHER'S MAIDEN NAME | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | |
| Elizabeth Biroost | | 16. SOCIAL SECURITY NO | |
| 17. INFORMANT | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | |
| Address | | DUE TO <i>gas & CO. electrical hazard, by -</i> | |
| Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. | | (b) <i>in bacteria</i> | |
| (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Hour a. m. <input type="checkbox"/> p. m. <input type="checkbox"/> 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>Aug 18 59</i> , 1959, to <i>Aug 18 59</i> , 1959, that I last saw the deceased alive on <i>Aug 18 59</i> , 1959, and that death occurred at <i>112 Chase St., Baltimore, Md.</i> on the date stated above. ADDRESS (Street, city or town, state) <i>112 Chase St., Baltimore, Md.</i> DATE SIGNED <i>Aug 18 59</i> | | ACTUAL SIGNATURE <i>Philip Whittlesey</i> | |
| 22a. FUNERAL CREMATION REMOVAL (Specify) <i>Funeral</i> | | 22b. DATE THEREOF <i>Aug 18 59</i> | |
| 22c. NAME OF CEMETERY OR Crematory <i>Greenlawn</i> | | 22d. LOCATION (City, town, or county) <i>Baltimore Md.</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Stewart Home</i> | | 24a. REC'D BY REGISTRAR DATE <i>AUG 18 59</i> | |
| ADDRESS <i>108 W York St., Baltimore, Md.</i> | | 24b. REGISTRAR'S SIGNATURE <i>Carrie S. Evans</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with
page 3 should be detached for use as the burial-trap permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

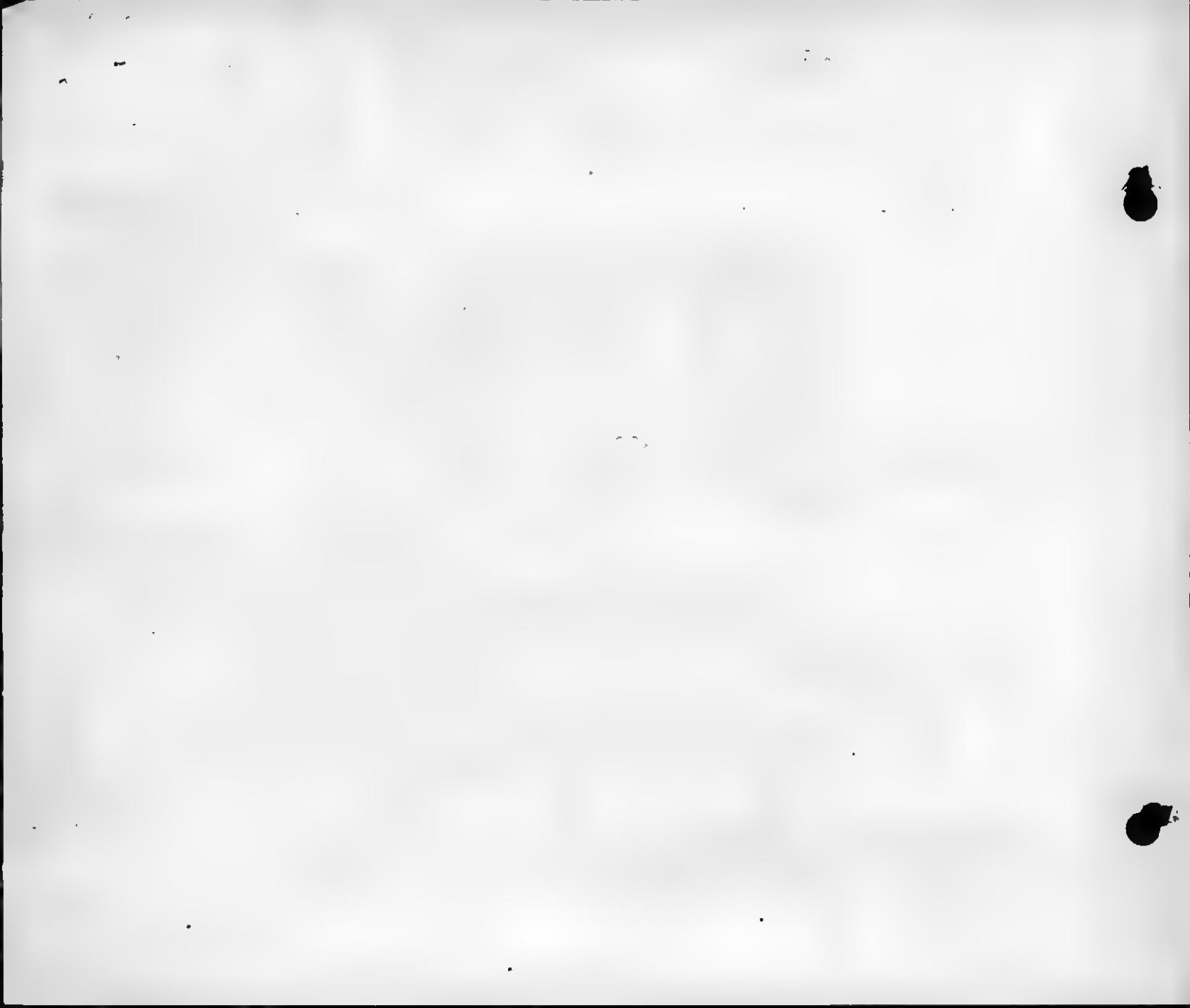
08883

8912

CERTIFICATE OF DEATH

Reg. Dist. No. ~

| | | | |
|--|----------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | 2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| baltimore Catoonsville Catoonsridge Nursing home | | MARYLAND 7 wks. Glen Burnie, Md. #201 Cedar Drive, Marley Park | |
| 3. NAME OF DECEASED (Type or print) H. A. V. VOGEL | | 4. DATE OF DEATH Month Day Year August 27, 1959 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 8 Aug. 1882 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MOS. WORK | | 10b. KIND OF BUSINESS OR INDUSTRY own home | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland |
| 13. FATHER'S NAME (unknown) | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. 121-3123337 | 17. INFORMANT Mrs. Clara R. Postet |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. AGE (In years last birthday) yrs 77 IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) left side Cerebral vascular accident went to | |
| 20c. TIME OF INJURY Hour o. m. p. m. | Month Day Year 19 | 20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) Baltimore |
| 21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, 19____, from the causes and on the date stated above. | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| ACTUAL SIGNATURE CLIFF RATLIFF JR. | | ADDRESS (Street, city or town, state) 4605 E. 31st Avenue, Denver, Colo. DATE SIGNED 1959 | |
| 22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial | 22b. DATE THEREOF 31 Aug. '59 | 22c. NAME OF CEMETERY OR CREMATORIAL Loudon Park Cem. | 22d. LOCATION (City, town, or county) Baltimore, Md. (State) |
| 23. FUNERAL DIRECTOR'S SIGNATURE R. P. Singleton | | 24a. REC'D BY REGISTRAR DATE AUG 31 '59 | 24b. REGISTRAR'S SIGNATURE Arthur L. Hause |
| PHYSICIAN'S NAME (Type) CLIFF RATLIFF JR. | | | |



TO HOSPITAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 1 and 2 should be filed with the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. The registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8913

CERTIFICATE OF DEATH

Reg. Dist. No. 08884

| | | | | | | | | |
|--|----------------------------------|---|--|--|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland | | b. COUNTY | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard | | c. LENGTH OF STAY IN 1b 11 Days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (13) | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital | | | | d. STREET ADDRESS 1920 North Chester Street | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) GEORGE | | First | Middle | Last | 4. DATE OF DEATH VOGTMAN | Month | Day | Year |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH April 20, 1899 | 9. AGE (in years last birthday) 60 | 10. IF UNDER 1 YEAR Months 0 | 11. IF UNDER 24 HRS Days 0 | 12. IF UNDER 24 HRS Hours 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY produce | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | |
| 13. FATHER'S NAME John Vogtmann | | | 14. MOTHER'S MAIDEN NAME Mary Dennis Nordoff | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO. WW II | | INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland | | Address | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma DO TO Carcinoma, Right Lung Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DO TO (c) | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1. Arteriosclerotic Heart Disease. 2. Osteo Arthritis. 3. Benign prostatic Hypertrophy. | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. VA | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) VA | | 20f. (City or town) (County) (State) | | |
| 21. I certify that I attended the deceased from July 10, 1959 to August 20, 1959 and that death occurred at 9:10 A.M. from the causes and on the date stated above. | | | | | | | | |
| ACTUAL SIGNATURE <i>John W. Crawford</i> | | ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND DATE SIGNED 8/20/59 | | | | | | |
| PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, M.D. | | M.D. VAH, FORT HOWARD, MARYLAND DATE SIGNED 8/20/59 | | | | | | |
| 22a. BURIAL/CREMATION/REMOVAL (Specify) Burial | | 22b. DATE THEREOF 8/24/59 | | 22c. NAME OF CEMETERY OR CREMATORIAL Baltimore Cemetery | | 22d. LOCATION (City, town, or county) Baltimore, Maryland (State) | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Charles L. Schimunek Funeral Home | | ADDRESS 333 Brehms Lane | | 24a. REC'D BY REGISTRAR Arthur S. Thomas | | 24b. REGISTRAR'S SIGNATURE Arthur S. Thomas | | |
| | | DATE AUG 21 59 | | | | | | |



TO HOSPITAL
may be referred to the hospital or attending physician.
TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

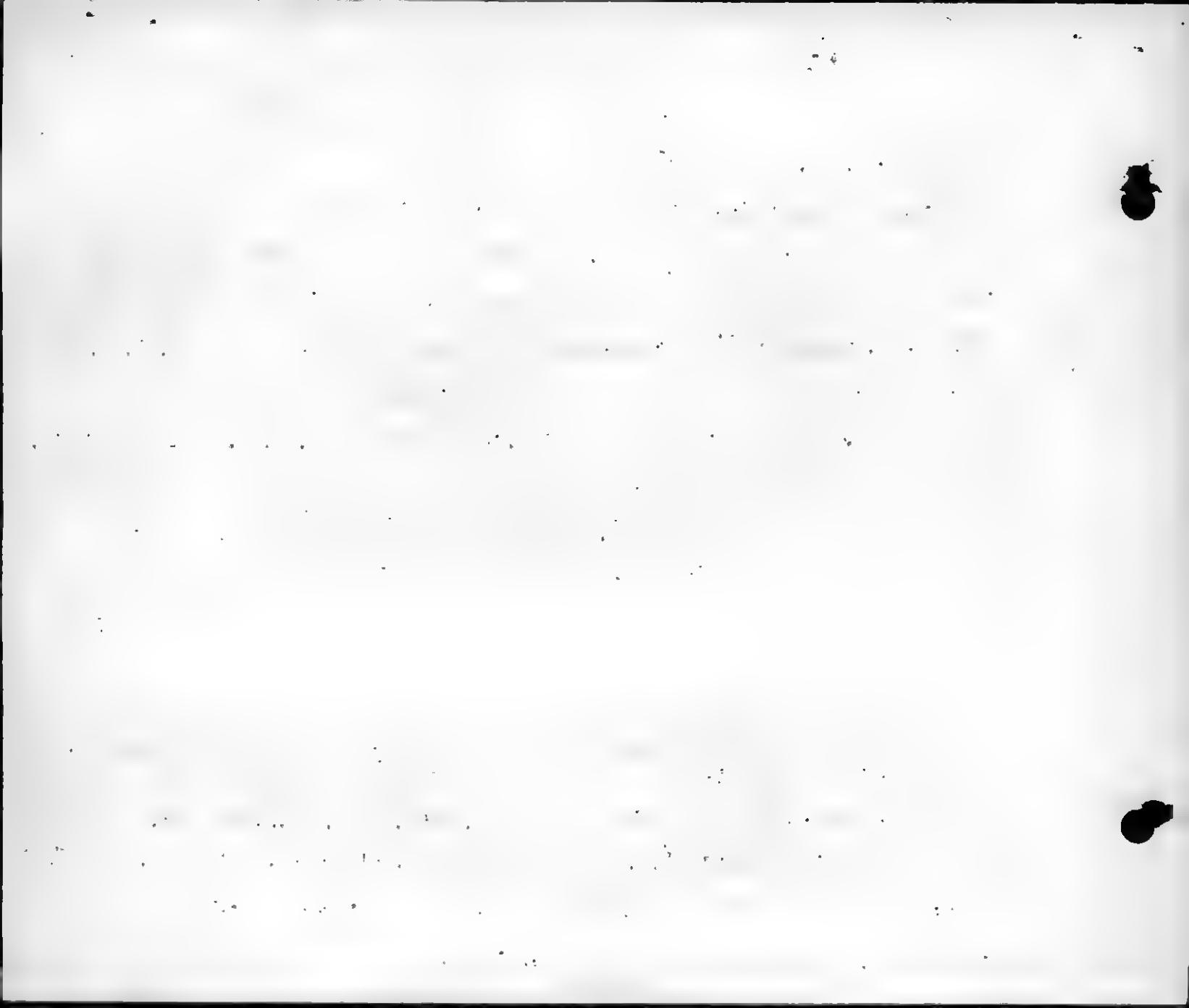
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15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8914 CERTIFICATE OF DEATH

Reg. Dist. No. 08885

| | | | | | |
|---|--|---|---|---|--|
| 1. PLACE OF DEATH o COUNTY Baltimore | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o STATE Maryland b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Md. | | c. LENGTH OF STAY IN 1b 38 Days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital | | | | d. STREET ADDRESS 130 Aisquith Street (2) | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) EDGAR | | First W. | Middle W. | Last WADDELL | 4. DATE OF DEATH August 25, 1959 |
| 5. SEX Male | | 6. COLOR OR RACE Colored | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH April 23, 1899 | 9. AGE (In years last birthday) 60 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Power Mach. Operator | | 10b. KIND OF BUSINESS OR INDUSTRY Customs House | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | |
| 13. FATHER'S NAME George Waddell | | | | 14. MOTHER'S MAIDEN NAME Anna Brummel | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO. WW I | | INFORMANT Clin. Records, VAH, Balto. 18, Md. Fort Howard Div. | Address |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>OBSTRUCTIVE JAUNDICE</u> DUE TO <u>MASSIVE HEMATOMA, LIVER AND GALL BLADDER FOSSA</u> INTERVAL BETWEEN ONSET AND DEATH <u>RECENT</u> | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ANEURYSMS, COMMON ILLIACS AND RADIAL ARTERIES</u> (c) <u>ARTERIOSCLEROTIC HEART DISEASE</u> UNKNOWN OLD OLD | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) Baltimore | (County) (State) |
| 21. I certify that <u>VA</u> attended the deceased from <u>July 18, 1959</u> to <u>August 25, 1959</u> , and that death occurred at <u>6:15 A.M.</u> from the causes and on the date stated above. | | | | | |
| ADDRESS (Street, city or town, state) <u>VAH, BALTO. 18, MD., FT. HOWARD DIV.</u> DATE SIGNED <u>8/25/59</u> | | | | | |
| ACTUAL SIGNATURE <i>Clovis M. Snyder, M.D.</i> | | PHYSICIAN'S NAME (Type) <u>CLOVIS M. SNYDER, M.D.</u> VAH, BALTO. 18, MD., FT. HOWARD DIV. 8/25/59 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 8-28-59 | 22c. NAME OF CEMETERY OR CREMATORIAL AUGUST 27, 1959 BALTIMORE VAH, BALTO. 18, MD., FT. HOWARD DIV. | 22d. LOCATION (City, town, or county) Baltimore, Maryland | (State) |
| 23. FUNERAL DIRECTOR'S SIGNATURE Randolph J. Collick | | ADDRESS 1112 E. Preston St., Balto. | 24a. REC'D BY REGISTRAR AUG 27 '59 | | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i> |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08886

8915

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|--|---|--|---|--|--|-----------------------------------|
| 1. PLACE OF DEATH a. COUNTY BALTIMORE | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND | | b. COUNTY BALTO. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE | | c. LENGTH OF STAY IN lb LIFE | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 702 OLD HOME ROAD | | | | d. STREET ADDRESS 702 OLD HOME ROAD | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) EDWARD | | First J. | Middle H. | Last WALTER | | 4. DATE OF DEATH AUGUST 10 | Month 1959 |
| 5. SEX MALE | | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH 5-30-1879 | | 9. AGE (In years last birthday) 80 | IF UNDER 1 YEAR Months Days |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINIST | | 10b. KIND OF BUSINESS OR INDUSTRY BLACK & DECKER CO. | | 11. BIRTHPLACE (State or foreign country) BALTO., MD. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME UNKNOWN | | | | 14. MOTHER'S MAIDEN NAME UNKNOWN | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. 215-18-7353 | | 17. INFORMANT EDWARD J. WALTER | | Address 702 OLD HOME ROAD | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Arteriosclerotic heart disease DUE TO DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH one week not determined | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>August 5, 1959</u> to <u>August 10, 1959</u> , that I last saw the deceased alive on <u>August 10, 1959</u> , and that death occurred at <u>4:30 P.M.</u> from the causes and on the date stated above ACTUAL SIGNATURE <u>Santi Amoroso</u> M.D. ADDRESS (Street, city or town, state) Santi Amoroso M.D. 6801 Belair Rd. Baltimore 6 Md. DATE SIGNED 8-12-59 | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 8-14-1959 | | 22c. NAME OF CEMETERY OR CREMATORIAL BOHEMIA NAT'L CEM. | | 22d. LOCATION (City, town, or county) BALTO. (State) MD. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Lorraine Jan Hornb</u> | | ADDRESS 7401 Belair Rd. | | 24a. REC'D BY REGISTRAR AUG 14 1959 DATE | | 24b. REGISTRAR'S SIGNATURE Celia S. Kline | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8916

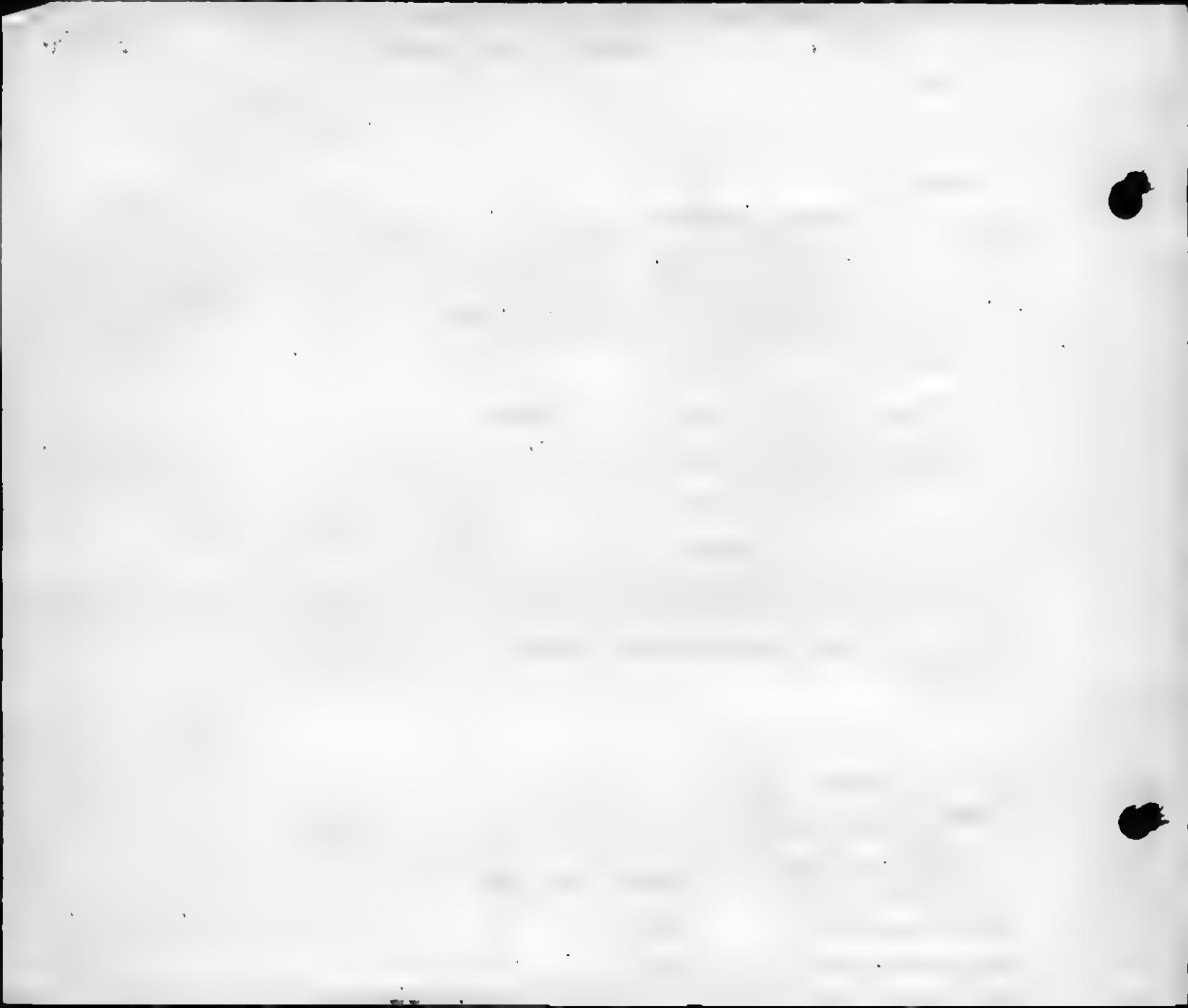
CERTIFICATE OF DEATH

05887

Reg. Dist. No.

| | | | |
|--|--|--|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore | | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1811 Deveron Road | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) EVELYN M. | | First | Middle |
| 4. DATE OF DEATH AUGUST 4 1959 | | Month | Day |
| 5. SEX female | | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 8. DATE OF BIRTH Feb. 8, 1886 | | 9. AGE (In years last birthday) 73 yrs. | 10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Montrose, Penna. |
| 12. CITIZEN OF WHAT COUNTRY USA | | 13. FATHER'S NAME Henry White | |
| 14. MOTHER'S MAIDEN NAME Anna Christian | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mr. Glenn Entrekin 1811 Deveron Road. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA | | 19. INTERVAL BETWEEN ONSET AND DEATH 24 HOURS | |
| DUE TO LEFT VENTRICULAR FAILURE | | 20. DUE TO ONE YEAR OR MORE | |
| Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. VENTRICULAR FAILURE | | 21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) RHEUMATIC VALVULAR DISEASE | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) Montgomery (State) Maryland | |
| 21. I certify that I attended the deceased from 10/11 , 19 58 , to 8/4 , 19 59 , that I last saw the deceased alive on 8/4 , 19 59 , and that death occurred at 11:50 P.M. , from the causes and on the date stated above. | | 22. ADDRESS (Street, city or town, state) 25 West Pennsylvania Ave 8/4/59 | |
| ACTUAL SIGNATURE Donald L. Somerville | | DATE SIGNED 8/4/59 | |
| PHYSICIAN'S NAME (Type) DONALD L. SOMERVILLE, MD | | 23. BURIAL, CREMATION, REMOVAL (Specify) Burial 8/8/59 | |
| 24. DATE THEREOF 8/8/59 | | 25. NAME OF CEMETERY OR CREMATORIUM Moscow Cemetery | |
| 26. LOCATION (City, town, or county) Lackawanna Co. Penna. | | 27. FUNERAL DIRECTOR'S SIGNATURE Leonard L. Ruck 5305 Harford Road #14 | |
| 28. ADDRESS Leonard L. Ruck 5305 Harford Road #14 | | 29. REC'D BY REGISTRAR DATE AUG 7 '59 | |
| 30. REGISTRAR'S SIGNATURE Arthur S. Krause | | | |

TO HOSPITAL OR CLINIC: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



| MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 | | | | | | | | | | Reg. Dist. No. 08888 | | | |
|---|--|-------------------------------|---|---|--|---|---------------------|--|------------------------------|---|-------------------------|------------|------|
| 8917 CERTIFICATE OF DEATH | | | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Md. | | | | | b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | | c. LENGTH OF STAY IN lb | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | | d. STREET ADDRESS 5911 Robindale Road | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5911 Robindale Road | | | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) | | First LOUIS F. WASHENFELDT | | Middle | | Last | | 4. DATE OF DEATH 8/20/59 | | Month | Day | Year 19 | |
| 5. SEX M | | 6. COLOR OR RACE W | | 7. MARRIED NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 12/18/79 | | 9. AGE (In years at birthday) 79 yrs | | IF UNDER 1 YEAR Months | IF UNDER 24 HRS Days | Hours | Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance Man | | | 10b. KIND OF BUSINESS OR INDUSTRY Alma Manuf. Co. | | | 11. BIRTHPLACE (State or foreign country) Maryland | | | 12. CITIZEN OF WHAT COUNTRY? | | | | |
| 13. FATHER'S NAME Leo | | | | | 14. MOTHER'S MAIDEN NAME Phillipine ? | | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | | 16. SOCIAL SECURITY NO. 215 05 6367 | | | 17. INFORMANT Family - Same | | | Address | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Her terminal condition</i> DUE TO <i>Her terminal condition</i> INTERVAL BETWEEN Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>Her terminal condition</i> DUE TO <i>Her terminal condition</i> <i>3 days</i> (c) <i>Her terminal condition</i> | | | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | |
| 20c. TIME OF INJURY Hour o. m. p. m. 19 | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | | (County) | | (State) | | |
| 21. I certify that I attended the deceased from <i>1957 to 1958</i> , <i>1957</i> , that I last saw the deceased alive on <i>Aug 18, 1957</i> , and that death occurred at <i>101-81 M</i> , from the causes and on the date stated above. | | | | | | | | | | ADDRESS (Street, city or town, state) | | | |
| ACTUAL SIGNATURE <i>Arthur S. Krause</i> | | | | | | | | | | DATE SIGNED <i>Aug 24, 1959</i> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) B | | 22b. DATE THEREOF 8/25/59 | | 22c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill | | | | 22d. LOCATION (City, town, or county) Baltimore (State) | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE McCully Funeral Homes - 130 E. Fort Avenue | | | | | ADDRESS | | | 24a. REC'D BY REGISTRAR DATE AUG 24 '59 | | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i> | | | |

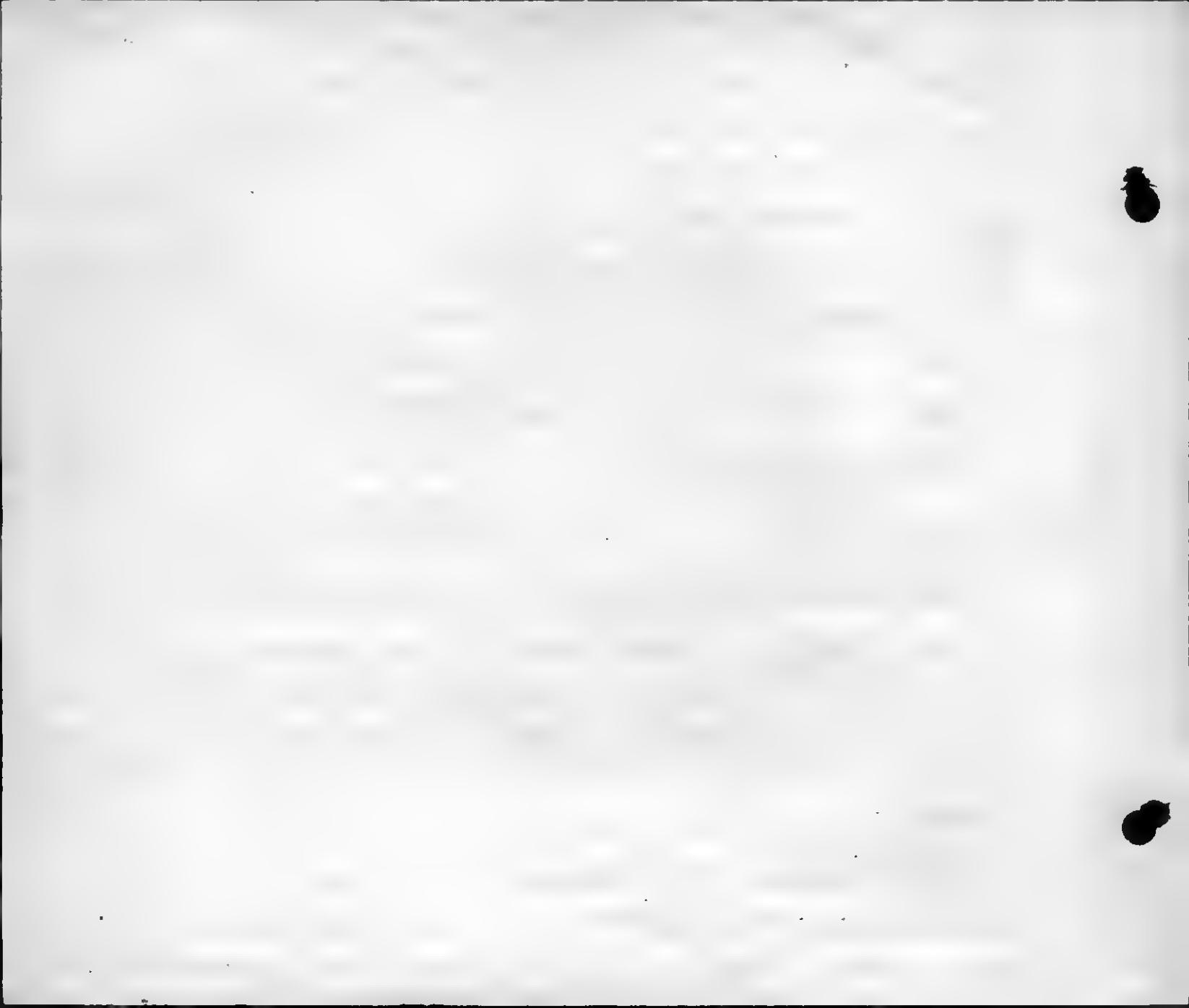


X 8918 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH 08889

| | | | | |
|---|----------------------------------|---|---|--|
| 1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COCKEYSVILLE | | c. LENGTH OF STAY IN 1b 14 YEARS | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MASONIC HOME | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BURTONSVILLE 15X | | |
| 3. NAME OF DECEASED (Type or print) WALTER WARFIELD WATERS | | First | Middle | |
| | | Lost | 4. DATE OF DEATH AUG. 14 1959 | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH 12-31-1872 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN | | 10b. KIND OF BUSINESS OR INDUSTRY MERCANTILE | 9. AGE (In years last birthday) 86 yrs. | |
| 13. FATHER'S NAME THOMAS WATERS | | 14. MOTHER'S MAIDEN NAME MARTHA DAWSON | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No | | 16. SOCIAL SECURITY NO. 214-03-8112 | 17. INFORMANT Frank L. Smith Jr. Cockeysville, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | INTERVAL BETWEEN ONSET AND DEATH | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 8-1 1959 to 8-14 1959 , that I last saw the deceased alive on 8-14 1959 , and that death occurred at 7:45 P.M. from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) Cockeysville, Md. DATE SIGNED 8/14/59 | | |
| ACTUAL SIGNATURE Elizabeth B. Sherrill | | PHYSICIAN'S NAME (Type) Elizabeth B. Sherrill | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 8-17-59 | 22c. NAME OF CEMETERY OR CREMATORIAL St. Marks of Fairland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul Street | | ADDRESS Wm. Cook, Inc., 1217 St. Paul Street | 24a. REC'D BY REGISTRAR AUG 17 1959 | 24b. REGISTRAR'S SIGNATURE Cathleen S. Kline |



| MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 | | | | | | | | | | | | 08890 | | | | | | | |
|--|--|------------------------------|---|---|--|--|--|--|---|------------------------------------|--|---|--|---|--|--|--|-----------------------|--|
| Item 1 FilmG246 3-21-59 et | | | | | | | | | | | | Reg. Dist. No. | | | | | | | |
| 8919 CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY BALTO. | | | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND | | | | | | b. COUNTY MARYLAND | | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL-ROCKDALE | | | | | | c. LENGTH OF STAY IN 1b 6 WEEKS | | | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - WOODLAWN | | | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: <i>Friend's home</i> 8311 LIBERTY Rd. | | | | | | d. STREET ADDRESS 6603 WINDSOR MILLE | | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) | | | First MARY | Middle EMILY | Last WERER | 4. DATE OF DEATH AUGUST 14 1959 | | | Month AUGUST | Day 14 | Year 1959 | | | | | | | | |
| 5. SEX F | | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Aug 15 1875 | | | 9. AGE (In years last birthday) 73 yrs. | 10. IF UNDER 1 YEAR Months 0 | | 11. IF UNDER 24 HRS. Days 0 | | | | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | | | | | 10b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE | | | | | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | | | | | | |
| 12. CITIZEN OF WHAT COUNTRY U.S.A. | | | | | | | | | | | | | | | | | | | |
| 13. FATHER'S NAME EDWARD COOMES | | | | | | 14. MOTHER'S MAIDEN NAME ZD EPHINE FEDDING RD | | | | | | | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | | | | | 16. SOCIAL SECURITY NO. 216-28-3758 | | | | | | 17. INFORMANT Son - EDWARD WERER 3524 STEAMER RD | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | | Address | | | | | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 199.2 | | | | Terminal Hemorrhage - Hemorrhage | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 2 hours | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. | | | | DUE TO Generalized Cerebrovascular | | | | | | | | 1/2 hour | | | | | | | |
| (b) | | | | DUE TO Coronary Artery Disease - Congestive Heart Failure | | | | | | | | 2 hours | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) | | | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. p.m. 19 | | | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) M.D. | | (County) | | (State) | | | | | |
| 21. I certify that I attended the deceased from JUNE 15, 1951 to AUGUST 14, 1959 , that I last saw the deceased alive on AUGUST 14, 1959 , and that death occurred at 11:30 P.M. from the causes and on the date stated above. | | | | | | | | | | | | ADDRESS (Street, city or town, state) 8204 LIBERTY Rd., BALTIMORE, MD 21211 | | DATE SIGNED 8/14/59 | | | | | |
| ACTUAL SIGNATURE <i>Edwin Pierpoint</i> | | | | | | 22. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | | | 22b. DATE THEREOF 8-18-1959 | | 22c. NAME OF CEMETERY OR CREMATORIAL Woodlawn | | 22d. LOCATION (City, town, or county) Woodlawn | | (State) Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Howard Sherry Brogden</i> | | | | | | ADDRESS 307 E. 36th St., New York, N.Y. | | | | | | 24a. REC'D BY REGISTRAR AUG 17 1959 | | 24b. REGISTRAR'S SIGNATURE <i>Edwin S. Pierpoint</i> | | | | | |
| | | | | | | | | | | | | | | | | | | | |



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

06891

8920

Reg. Dist. No.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

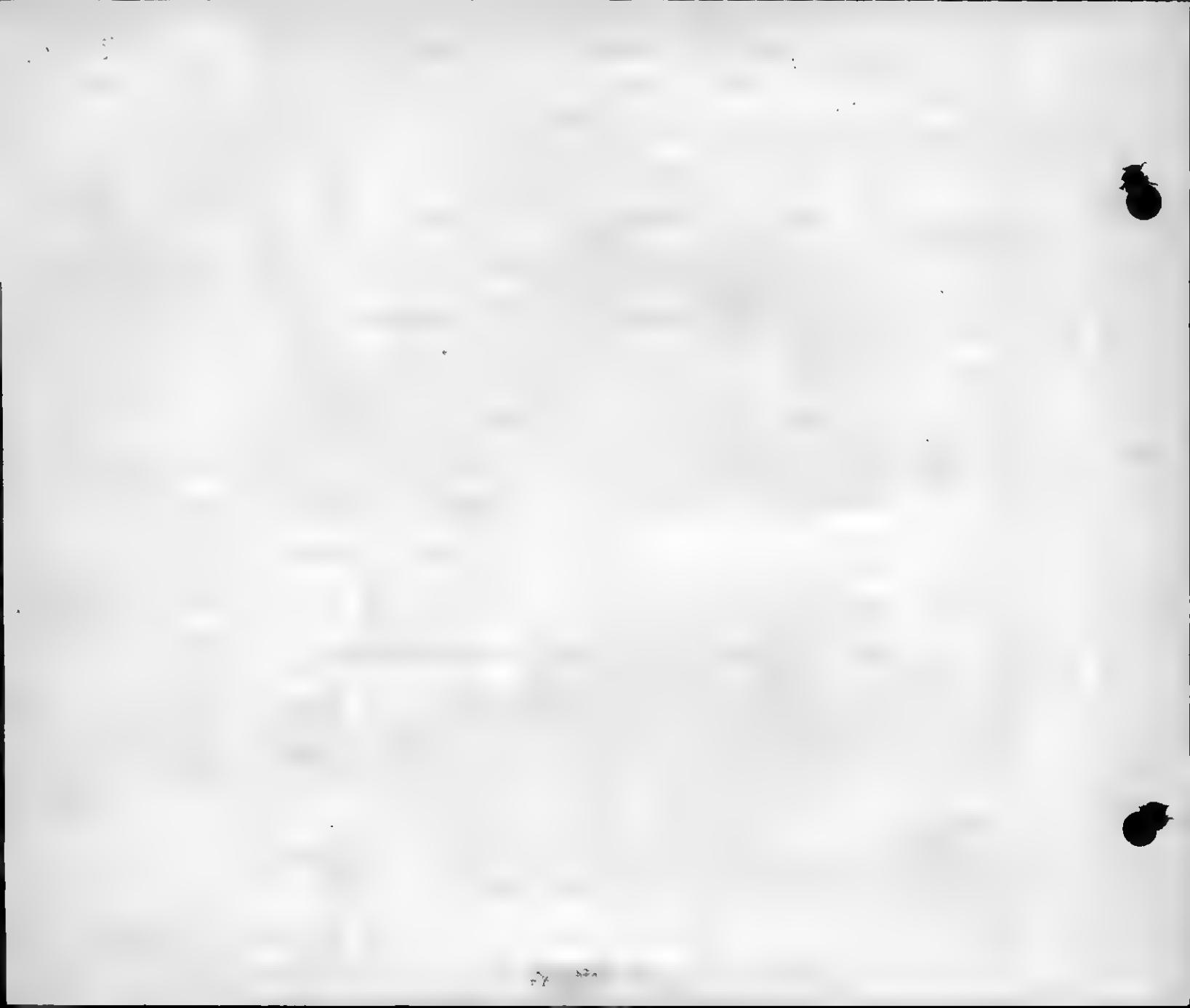
FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the registrar prior to burial, cremation,

5) writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the medical Examiner's Office along with form PM3. Give Page 5 to the registrars for your files.

DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation,

TO FUNERAL DIRECTOR: Page 3 should be used as a burial permit. File pages 1 and 2 with the county coroner. Page 4 may be required for burial services using a non-permit.

| | | | | | |
|--|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY | | Baltimore Maryland | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. LENGTH OF STAY IN lb | | d. STATE <u>MD.</u> b. COUNTY <u>BALTIMORE</u> | |
| Baltimore 12 | | ? | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | e. STREET ADDRESS | | d. STREET ADDRESS <u>Baltimore 12</u> | |
| 241 B. RODDERS FORGE AV | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | e. STREET ADDRESS <u>241 B RODDERS FORGE AV</u> | |
| 3. NAME OF DECEASED (Type or print) | | First <u>JOHN</u> | Middle <u>CLARENCE</u> | Last <u>WERNETH</u> | 4. DATE OF DEATH Month <u>AUG.</u> Day <u>3</u> Year <u>1959</u> |
| 5. SEX <u>M</u> | | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>May 20, 1884</u> | 9. AGE (In years lost birthright) <u>75 yrs.</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| PHOTO ENGRAVING | | SELF EMPLOYED | | Balto. MD. | |
| 13. FATHER'S NAME <u>JOSEPH</u> | | 14. MOTHER'S MAIDEN NAME <u>KOHLOPP</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>212-07-2889</u> | | 17. INFORMANT <u>FRANK L. WERNETH</u> Address <u>2621 HILLCREST #14</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> | | | | | |
| DUE TO Conditions, if any, which give rise to immediate cause (b) | | | | | |
| DUE TO Conditions, if any, which give rise to immediate cause (c) | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | |
| 20c. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>1P</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>2621 HILLCREST</u> (County) <u>BALTIMORE</u> (State) <u>MARYLAND</u> | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE <u>William A. Pillsbury</u> | | M.D., CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED <u>8/5/59</u> | |
| EXAMINER'S NAME (Type) <u>William A. Pillsbury</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>8/8/59</u> | | 22c. NAME OF CEMETERY OR CREMATORIAL <u>Loudon Park Cemetery</u> 22d. LOCATION (City, town, or county) <u>Baltimore, Maryland</u> (State) <u>MARYLAND</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>WILLIAM A. PILLSBURY</u> | | ADDRESS <u>1214 E. 36th St.</u> | | 24a. REC'D BY REGISTRAR DATE <u>AUG 6 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur & Kline</u> | |



TO HOSPITAL OR
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

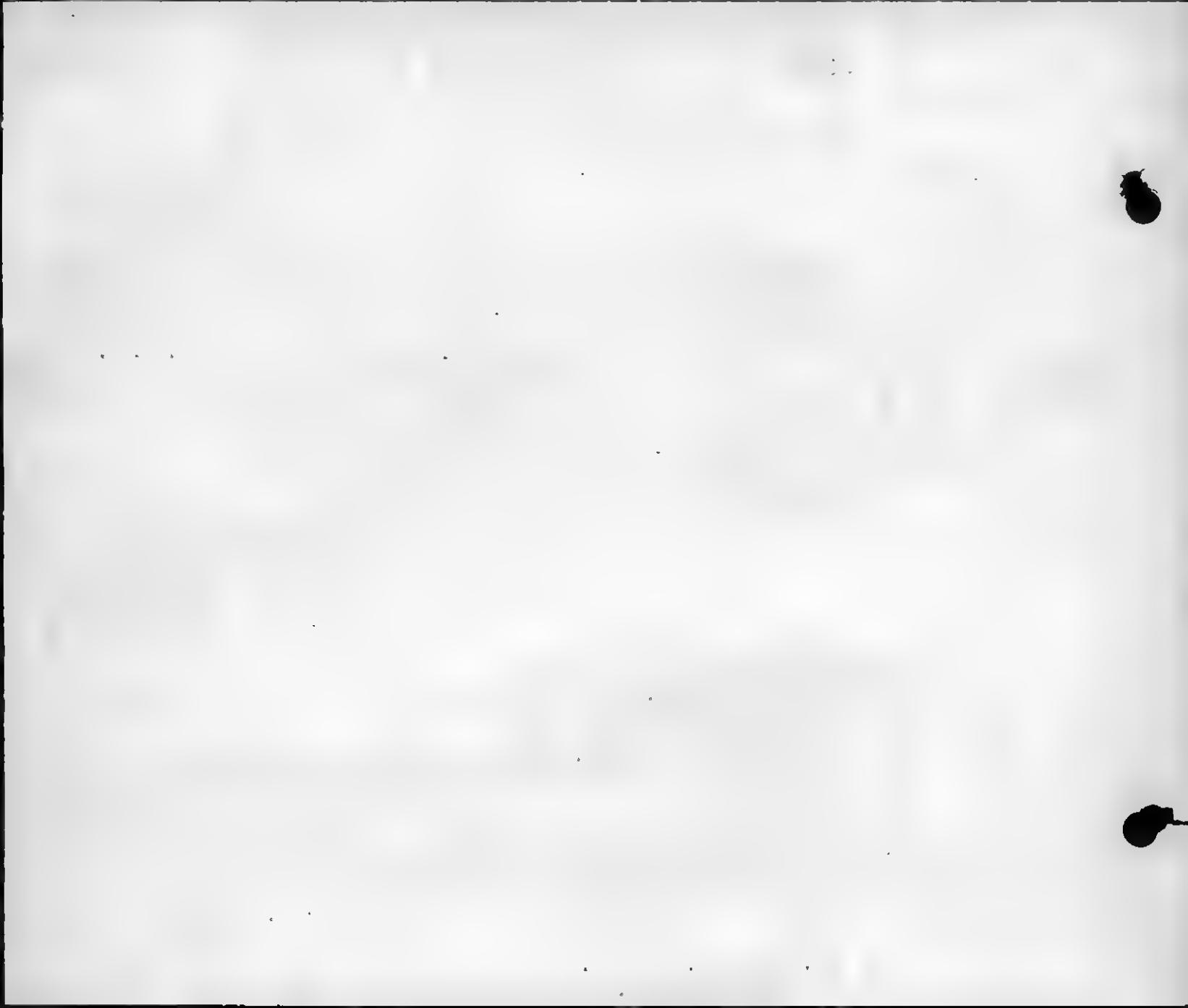
8921

CERTIFICATE OF DEATH

Reg. Dist. No.

08892

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | c. LENGTH OF STAY IN lb 2yr9mth21days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | First Frank | Middle Oscar | Last White |
| 4. DATE OF DEATH | Month 8 | Day 1 | Year 1959 |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Oct. 22, 1883 |
| 9. AGE (In years last birthday) 75 | 10. IF UNDER 1 YEAR Months 0 | 11. IF UNDER 24 HRS Days 0 | 12. IF UNDER 24 HRS Hours 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Maryland | 12. CITIZEN OF WHAT COUNTRY? U. S. A. |
| 13. FATHER'S NAME (Unknown) | 14. MOTHER'S MAIDEN NAME (Unknown) | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown | |
| 16. SOCIAL SECURITY NO. Unknown | 17. INFORMANT Records: SPRING GROVE STATE HOSPITAL | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4. / DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic brain syndrome associated with cerebral arteriosclerosis | | INTERVAL BETWEEN ONSET AND DEATH 3 weeks | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) car accident | | |
| 20c. TIME OF INJURY Hour a.m. p.m. | Month 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from Sept. 26, 1956, to 8/1/1959, that I last saw the deceased alive on 8/1/1959, and that death occurred at 2:20 PM, from the causes and on the date stated above. ACTUAL SIGNATURE <i>Bruno Radauskas</i> M.D. PHYSICIAN'S NAME (Type) <i>BRUNO RADAUSKAS</i> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 8/3/59 | 22c. NAME OF CEMETERY OR CREMATORIUM Woodlawn Cemetery | 22d. LOCATION (City, town, or county) Baltimore, Maryland (State) |
| 23. FUNERAL DIRECTOR'S SIGNATURE William Cook Inc., 1217 St. Paul St., Baltimore, Md. | ADDRESS | 24a. REC'D BY REGISTRAR DATE AUG 4 '59 | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i> |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08893

8922

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH o. COUNTY Baltimore | | 2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) o. STATE Maryland | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 14, | | b. COUNTY Baltimore | |
| c. LENGTH OF STAY IN 1b Baltimore 14, | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 14 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2434 Ellis Rd. | | d. STREET ADDRESS 2434 Ellis Rd. | |
| 3. NAME OF DECEASED (Type or print) Laura Rosalee Wilkinson | | 4. DATE OF DEATH 8-1-59 | Month Day Year 19 |
| S SEX female | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 11-18-1870 |
| 9. AGE (In years last birthday) 88 yrs. | | 10. IF UNDER 1 YEAR Months 0 | 11. IF UNDER 24 HRS Days 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | 10b. KIND OF BUSINESS OR INDUSTRY home | 11. BIRTHPLACE (State or foreign country) Maryland |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME John Staub | |
| 14. MOTHER'S MAIDEN NAME Mary Blondel | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | |
| 16. SOCIAL SECURITY NO. none | | 17. INFORMANT Estelle Wilkinson, | Address above |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic heart disease</i> | | INTERVAL BETWEEN ONSET AND DEATH 6 mo. | |
| DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 3408 Windsor Ave |
| 20f. (City or town) Baltimore | | (County) 8/3/59 | |
| (State) | | | |
| 21. I certify that I attended the deceased from 10/23 , 19 58 , to 8/11 , 19 59 , that I last saw the deceased alive on 7/31 , 19 59 , and that death occurred at 4:45 p.m. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>Robert A. Reiter</i> | | ADDRESS (Street, city or town, state) 3408 Windsor Ave | |
| PHYSICIAN'S NAME (Type) Robert A. Reiter, M.D. | | DATE SIGNED 8/3/59 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 8-4-59 | 22c. NAME OF CEMETERY OR CREMATORIUM Lorraine Park |
| 22d. LOCATION (City, town, or county) Baltimore, Woodlawn, Md. | | (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Brooks Funeral Service, Towson 4, Md. | | 24a. REC'D BY REGISTRAR Arthur S. Krause | 24b. REGISTRAR'S SIGNATURE Arthur S. Krause |
| VS A15 (4) 15M 9/55 | | DATE AUG 5 '59 | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

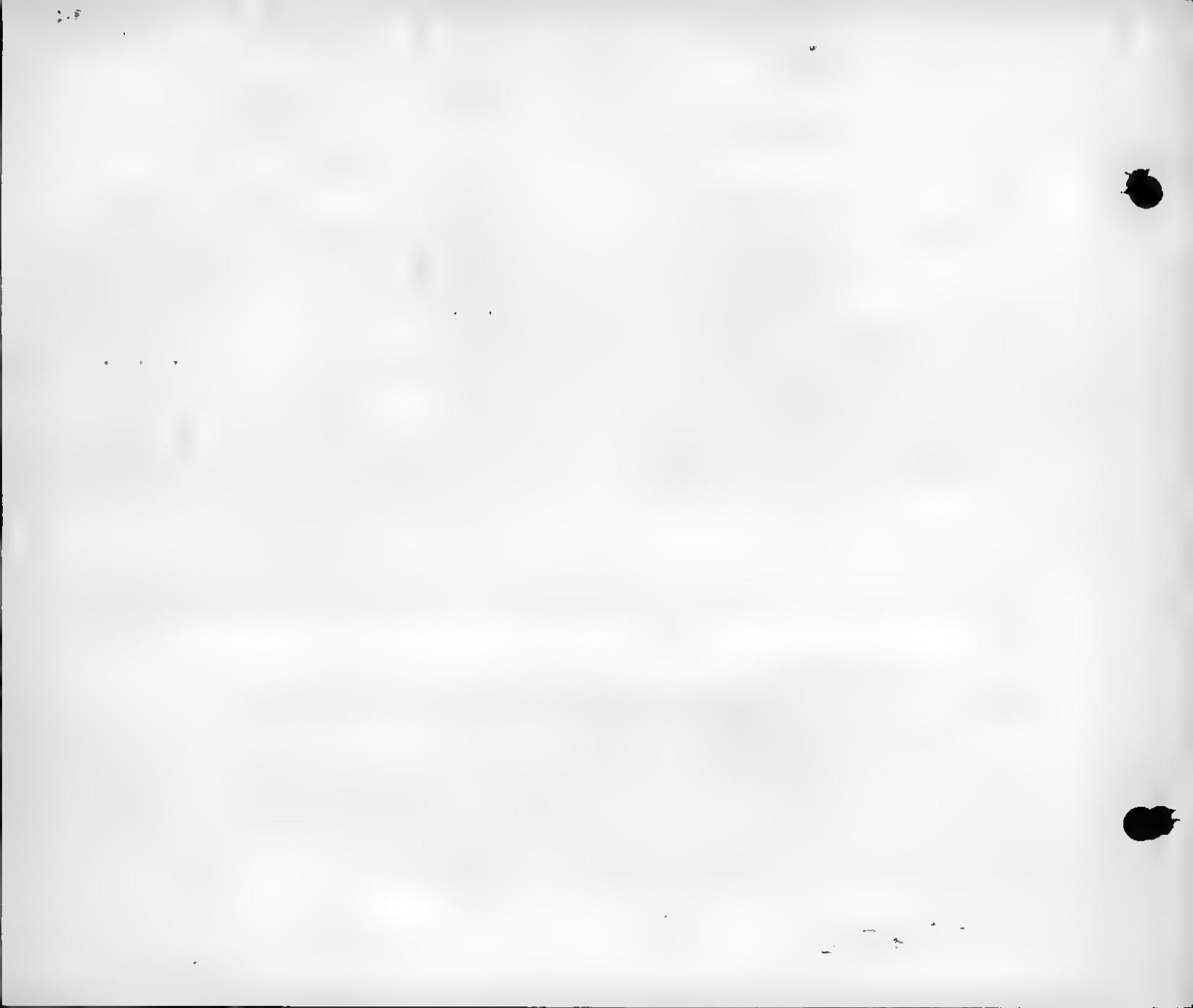
8923

CERTIFICATE OF DEATH

08894

Reg. Dist. No.

| | | | |
|--|--|--|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catoonsville | | c. LENGTH OF STAY IN 1b 5yr3mth25dys | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Elizabeth | | First | Middle |
| Last | | 4. DATE OF DEATH | Month |
| 5. SEX female | | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 8. DATE OF BIRTH Dec. 3, 1873 | | 9. AGE (In years last birthday) 85 yrs | 10. IF UNDER 1 YEAR Months Days Hours Min |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Baltimore Maryland | 12. CITIZEN OF WHAT COUNTRY? U. S. A. |
| 13. FATHER'S NAME Conrad Ackerman | | 14. MOTHER'S MAIDEN NAME Anne Binggold | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown | | 16. SOCIAL SECURITY NO. None | 17. INFORMANT Records; spring GROVE STATE HOSPITAL |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 100.4 DUE TO Hizzie J. in the | | INTERVAL BETWEEN ONSET AND DEATH | |
| Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from May 3, 1954, to May 28, 1954, that I last saw the deceased alive on May 23, 1954, and that death occurred at 11:15 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) | | | |
| ACTUAL SIGNATURE C. A. Ackerman | | DATE SIGNED | |
| PHYSICIAN'S NAME (Type) A. S. CAROTAN | | M.D. SPRING GROVE STATE HOSPITAL | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 8/31/59 | 22c. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet Cemetery |
| 22d. LOCATION (City, town, or county) Baltimore, Maryland | | (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Pickner & Sons Baltimore - 17. Md | | 24a. REC'D BY REGISTRAR AUG 31 1959 DATE | 24b. REGISTRAR'S SIGNATURE John A. Tamm |



TO HOSPITAL OR HOMECARE: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8768

08895

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halethorpe | | c. LENGTH OF STAY IN 1b 25 yrs | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4333 Ridge Ave. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Nettie Wisner | First | Middle | Last |
| 4. DATE OF DEATH August 23 | Month | Day | Year 1959 |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH December 24 1879 |
| | | WIDOWED <input type="checkbox"/> | 9. AGE (In years lost birthday) 79 yrs. |
| | | DIVORCED <input type="checkbox"/> | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Soles lady |
| | | | 10b. KIND OF BUSINESS OR INDUSTRY Bakery |
| | | | 11. BIRTHPLACE (State or foreign country) Maryland |
| | | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. |
| 13. FATHER'S NAME John Riggins | 14. MOTHER'S MAIDEN NAME Susan Hudson | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no, or unknown) No | 16. SOCIAL SECURITY NO. 214-22-7743 | 17. INFORMANT Harry Wisner 4333 Ridge Ave | Address |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hypertension A. S. C. V. D. | | | |
| DUE TO Pulmonary Edema | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Hour a. m. p. m. | Month 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from 8/2 , 1959, to 8/23 , 1959, that I last saw the deceased alive on 8/22 , 1959, and that death occurred at 405/1A M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>John C. Tracy</i> | ADDRESS (Street, city or town, state) Halethorpe Md | | |
| PHYSICIAN'S NAME (Type) John C. Tracy | DATE SIGNED 8/24/59 | | |
| 22a. BURIAL/CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 8/26/59 | 22c. NAME OF CEMETERY OR CREMATORIAL Western Cemetery | 22d. LOCATION (City, town, or county) Baltimore Maryland |
| 23. FUNERAL DIRECTOR'S SIGNATURE Amberly, Inc. 1328 Sulphur Spring Rd | ADDRESS Amberly, Inc. 1328 Sulphur Spring Rd | 24a. REC'D BY REGISTRAR Arthur S. Tracy | 24b. REGISTRAR'S SIGNATURE Arthur S. Tracy |
| | | DATE AUG 25 '59 | |



TO HOSPITAL **ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours of death. Page **1** of **4** may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

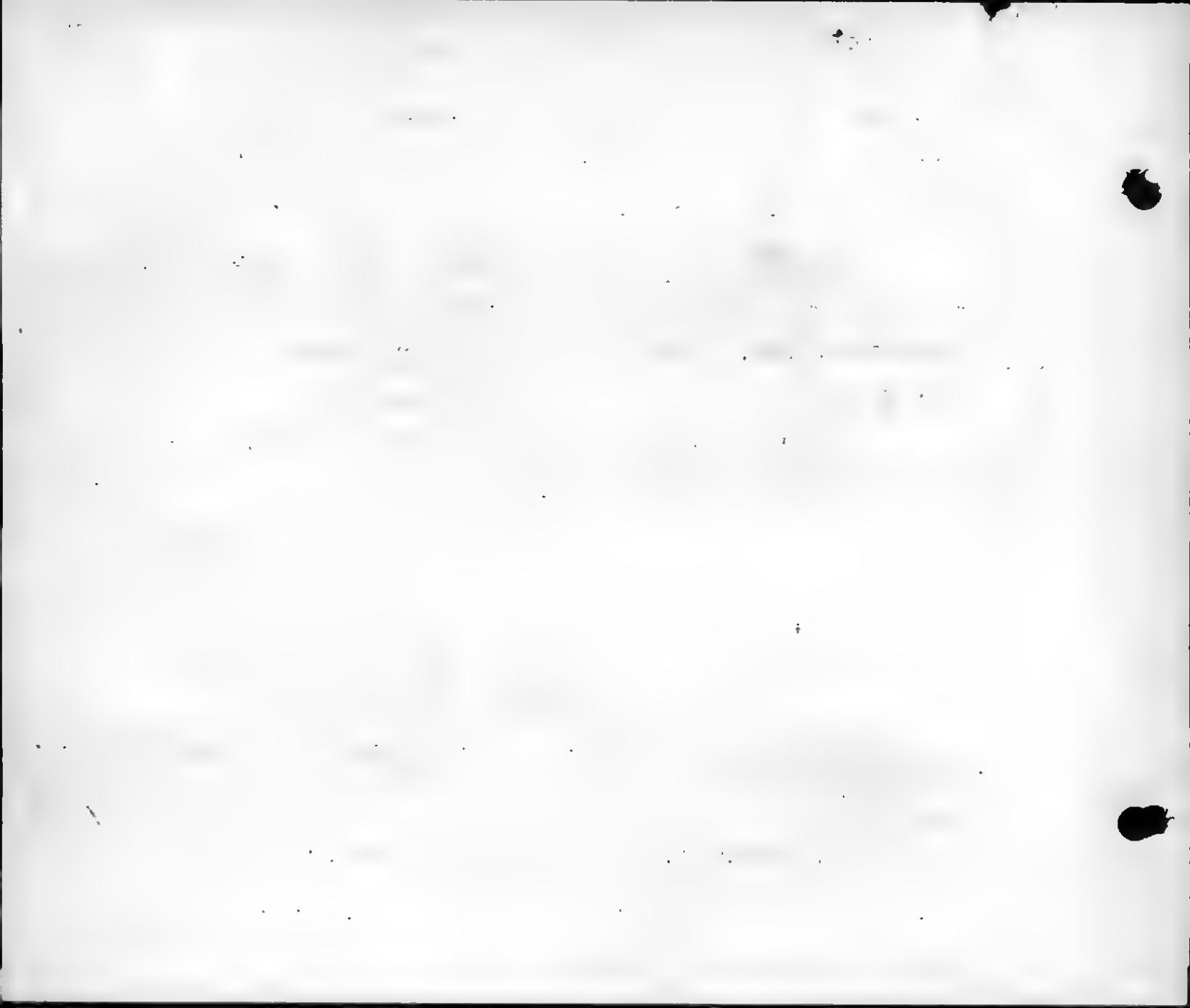
8924

CERTIFICATE OF DEATH

Reg. Dist. No.

08896

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore | | 2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard | | c. LENGTH OF STAY IN lb 36 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | |
| 3. NAME OF DECEASED (Type or print) THOMAS | | First C | Middle WOODEN |
| 4. DATE OF DEATH August | | Month 7 | Day 19 |
| 5. SEX Male | | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 8. DATE OF BIRTH January 4, 1887 | | 9. AGE (In years last birthday) 72 yrs. | 10. IF UNDER 1 YEAR Months 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baltimore Fireman, Ret. | | 10b. KIND OF BUSINESS OR INDUSTRY Balto. City | 10c. BIRTHPLACE (State or foreign country) Baltimore, Maryland |
| 11. CITIZEN OF WHAT COUNTRY? U. S A | | 12. MOTHER'S MAIDEN NAME Louise Harriman | |
| 13. FATHER'S NAME Thomas Wooden | | 14. INFORMANT Clin. Rec. Vet. Adm. Hosp. Ft. Howard, Md | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO. 218-07-3381 | |
| 17. INTERVAL BETWEEN ONSET AND DEATH 10 days | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hypertension | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour o. m. p. m. VA | | 20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from July 2, 1959 , to August 7, 1959 , and that death occurred at 5:00A M , from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) VAH FT HOWARD, MD | |
| ACTUAL SIGNATURE <i>John W. Crawford</i> | | M.D. | |
| PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, M.D. | | DATE SIGNED 8/3/59 | |
| 22a. BURIAL, CREMATION REMOVAL (Specify) Burial | | 22b. DATE THEREOF 8-11-59 | 22c. NAME OF CEMETERY OR CREMATORIUM Baltimore National |
| 22d. LOCATION (City, town, or county) Baltimore, Maryland | | (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Cyach Funeral Home 901 N. Chester St. Balt. Md | | 24a. REC'D BY REGISTRAR VS A15 (4) | 24b. REGISTRAR'S SIGNATURE 15M 9/58 |
| ADDRESS VS A15 (4) | | DATE AUG 11 '59 | ADDRESS Caroline S. Kline |



FOR STATE
HEALTH DEPT.

1. **TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death, if any delay is necessary, please execute the same date, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
2. **TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-tranit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8925 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08897

Reg. Dist. No.

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upperco | | c. LENGTH OF STAY IN 16 X Upperco | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Hanover Road | | d. STREET ADDRESS Hanover Road | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First ALBERT Middle YAREMA | | 4. DATE OF DEATH Last 6-22-1895 Month August Day 15 Year 1959 | |
| 5. SEX Male White | | 6. COLOR OR RACE WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH 6-22-1895 | |
| 9. AGE (In years last birthday) 64 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tavern Owner | |
| 11. BIRTHPLACE (State or foreign country) POLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME SIMON YAREMA | | 14. MOTHER'S MAIDEN NAME ? | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 385-26-0270 | |
| 17. INFORMANT MRS. ROSE YAREMA Hanover Rd Upperco Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 981X DUE TO Conditions, If any, which gave rise to immediate cause (b) (c) (d), stating the underlying cause lost. | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b) 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. 8/15 1959 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home | | 20f. (City or town) Upperco | |
| (County) Balto. | | (State) Md. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) W. Bradley King, Jr, MD | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 8-20-59 | |
| 22c. NAME OF CEMETERY OR CREMATORY MT. OLIVET | | 22d. LOCATION (City, town, or county) DETROIT MICH. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE John G. Connolly 418 Eastern Blk. | | 24a. REC'D BY REGISTRAR DATE AUG 19 '59 | |
| ADDRESS 1315 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Trahan | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8926

08898

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | | |
|--|--|---|---|---|------------------------|--|---|---------------|
| 1. PLACE OF DEATH a. COUNTY | | Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE | | Maryland b. COUNTY | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rosedale | | c. LENGTH OF STAY IN lb 10 Years | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rosedale | | Baltimore | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7931 Shirley Avenue | | | | d. STREET ADDRESS 7931 Shirley Avenue | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) | | First Mary | Middle A. | Lost Zaicko | 4. DATE OF DEATH | Month August | Day 20 | Year 19 59 |
| 5. SEX Female | | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Aug 13, 1900 | | 9. AGE (In years lost birthday) 59 yrs. | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | | 11. BIRTHPLACE (State or foreign country) Baltimore County, Md. | | 12. CITIZEN OF WHAT COUNTRY? | | |
| 13. FATHER'S NAME William Zeiters | | 14. MOTHER'S MAIDEN NAME Mary Calender | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mrs. Doris Popowicz | | Address 7931 Shirley Avenue | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 241X | | Coronary Occlusion | | | | immediate | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. | | DUE TO (b) Atherosclerosis - Diabetes Mellitus | | | | 10 yrs. | | |
| | | DUE TO (c) Chronic Bronchial Asthma | | | | 20 yrs. | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>51</u> , to <u>Aug 20</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>8/11</u> , 19 <u>59</u> , and that death occurred at <u>5 A.M.</u> , from the causes and on the date stated above. ACTUAL SIGNATURE <u>Joseph J. Cameron Jr.</u> M.D. 1515- MARTIN BLVD - BALTIMORE, MD. PHYSICIAN'S NAME (Type) JOSEPH J. CAMERON | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Aug 24, 1959 | | 22c. NAME OF CEMETERY OR CREMATORIUM Oak Lawn Cemetery | | 22d. LOCATION (City, town, or county) Baltimore, Maryland | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Lilly & Zeiler Inc., 1901 Eastern Avenue | | ADDRESS | | 24a. REC'D BY REGISTRAR DATE AUG 24 '59 | | 24b. REGISTRAR'S SIGNATURE Clothing & Home | | |

2025 RELEASE UNDER E.O. 14176

CONFIDENTIAL